89 10934

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): FRANK GOODMAN | | 2. DATE OF DEATH (Month, Day, Year): 04 18 89 | 3. TIME OF DEATH: 6 35 PM |
| 4. SOCIAL SECURITY NUMBER: 218-09-4381 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 90 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 05 06 98 | 8. BIRTHPLACE (State or Foreign Country): S.C. |
| 9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3223 Vickers Road | | 10f. ZIP CODE: 21216 | 10g. CITIZEN OF WHAT COUNTRY? U S A |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Isaac Goodman | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Charlotte |
| 19a. INFORMANT'S NAME (Type/Print): Carrie Brown | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3223 Vickers Road Baltimore, Md 21216 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt Auburn Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | RESPIRATORY ARREST | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | DEHYDRATION | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | SEPSIS | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus
Dementia

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD HOUSE OFFICER | 29c. LICENSE NUMBER: — | 29d. DATE SIGNED (Month, Day, Year): 4/18/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LOC. T. LE | | |
| 31. DATE FILED (Month, Day, Year): APR 21 1989 Julia | 32. REGISTRAR'S SIGNATURE: Dundon-Rinehart | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 10935

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JERI ALISE GORDON | | | 2. DATE OF DEATH (Month, Day, Year): 4 27 89 | 3. TIME OF DEATH: 1:23 PM |
| 4. SOCIAL SECURITY NUMBER: NONE | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 2 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3-24-87 | 8. BIRTHPLACE (State or Foreign Country): Md |
| 9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Balto City | | 9c. COUNTY OF DEATH: X |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | BALTIMORE | BALTIMORE | 1 ☐ YES 2 ☒ XX NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 7601 CARLA ROAD | 21208 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12): 0 | College (1-4 or 5+) | NONE | NONE |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| PAUL GORDON | JACQUELINE COHEN |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| PAUL GORDON | 7601 CARLA ROAD BALTO., MD 21208 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | MOSES MONTEFIORE CEMETERY | BALTIMORE, MARYLAND |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Ellenore Levinson | SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Overwhelming Sepsis | 2½ hours. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Purpura Fulminans

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| MD | D20742 | ▶ 4-17-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Daniel J. Leuck, MD. 10213 S. Dolfield Rd., Owings Mills, Md. 21117

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 20 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 0332

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-2-3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CALVIN M GONCE | | | 2. DATE OF DEATH (Month / Day / Year): 4 22 89 | 3. TIME OF DEATH: 11.45 M |
| 4. SOCIAL SECURITY NUMBER: 217-14-1464 | 5. SEX: 1 ☐ M 2 ☐ F — X | 6. AGE (In yrs. last birthday): 65 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): SEPT. 19, 1923 | 8. BIRTHPLACE (State or Foreign Country): BALTO. MD. |
| 9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD. | | 9c. COUNTY OF DEATH: BALTIMORE CITY | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE, MARYLAND | 10d. INSIDE CITY LIMITS? 1 ☒ YES — X 2 ☐ NO |
| 10e. STREET AND NUMBER: 2432 E. BALTIMORE STREET | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced — X | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO — X — Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CONCRETE MASON | 16b. KIND OF BUSINESS/INDUSTRY: CONSTRUCTION | |
| 17. FATHER'S NAME (First, Middle, Last): BENJAMIN N. GONCE | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET BRANNAN | | |
| 19a. INFORMANT'S NAME (Type/Print): MARVIN B. GONCE | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1014 ROSEMONT AVE. JOPPA, MD. 21085 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation — X 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MORELAND MEMORIAL CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John J Dippel Jr | 22. NAME AND ADDRESS OF FACILITY: DIPPEL FUNERAL HOME 7110 BELAIR ROAD BALTO. MD. 21206 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CANCER OF THE LUNG | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO — X | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient — X 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural — X 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Anthony Impagliatelli MD. | D16188 | ▶ 4/22/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): IMPAGLIATELLI MD. CHURCH HOSPITAL

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 24 1989 | Julia Davidson-Kendall |

DHMH-16 Rev 1/89

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10e
item #19b per FH film 650 4/13/89fj

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 10937

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): William P. Green | | | | | 2. DATE OF DEATH (Month, Day, Year): April 9, 1989 | 3. TIME OF DEATH: 10:50 AM |
| 4. SOCIAL SECURITY NUMBER: 241-30-5716 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 79 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 5/22/09 | 8. BIRTHPLACE (State or Foreign Country): NC |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE, MD | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1027 CATHEDRAL STREET RM ~~176~~ 17L | | 10f. ZIP CODE: 21201 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 6+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TILLEY CHEMICAL COMPANY | 16b. KIND OF BUSINESS/INDUSTRY: RETIRED |
| 17. FATHER'S NAME (First, Middle, Last): UNKNOWN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LILLIE | |
| 19a. INFORMANT'S NAME (Type/Print): THERESA GREEN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1027 CATHEDRAL STREET RM 17L BALTO., MD | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOUNT AUBURN CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Anthony Edward J. | | 22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Lung Carcinoma | 2 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): Diffuse Metastasis | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

~~Pulmonary Tuberculosis in the past two years~~

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 [ ] YES 2 [ ] ND |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 26d. DESCRIBE HOW INJURY OCCURED |
| | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Virginia M Lovett | 29c. LICENSE NUMBER: | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/9/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C/O Maryland General Hospital | | |
| 31. DATE FILED (Month, Day, Year): APR 13 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rankin | |

OHMH-16 Rev 1/89

89 1033

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 10938
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in applying for the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HARVEY J. GROVES | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 10, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 232-09-8101 | 5. SEX: 1 ☐ M 2 ☐ F (X) | 6. AGE (In yrs. last birthday): 72 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9-4-1916 |
| 8. BIRTHPLACE (State or Foreign Country): WEST VIRGINIA | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 3114 SOLLERS POINT ROAD | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH: BALTIMORE | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 3114 SOLLERS POINT ROAD | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): STEEL WORKER | 16b. KIND OF BUSINESS/INDUSTRY: BETHLEHEM STEEL CORP. | |
| 17. FATHER'S NAME (First, Middle, Last): STANLEY GROVES | 18. MOTHER'S NAME (First, Middle, Maiden Surname): GERTRUDE SWYERS | | |
| 19a. INFORMANT'S NAME (Type/Print): BERNICE M. GROVES | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3114 SOLLERS POINT ROAD BALTIMORE, MD 21222 | | |
| 20a. METHOD OF DISPOSITION: 1 (X) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OAKLAWN CEMETERY 4-13-89 | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Scott P. Gardner. | 22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MD 21222 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIO RESP ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CANCER of PROSTATE WITH MET TO BONES | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. CACHEXIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | D14221 | ▶ 4.10.89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): T. A. FURLONG MD 223 E. BLVD BALT. MD 21221

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 20 1989 | Julia Davidson-Randall |

OHMH-16 Rev 1/89

89 10939

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Marie E. Grund | | | | 2. DATE OF DEATH (Month, Day, Year): April 13, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 216-54-4183 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 93 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9-24-1895 | 8. BIRTHPLACE (State or Foreign Country): Balto. Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Augsburg Lutheran Home | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore,Md. | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4507 Mainfield Avenue | 10f. ZIP CODE: 21214 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): John F. Lehr | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Martha Heim | |
| 19a. INFORMANT'S NAME (Type/Print): Judy L. Scott | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4507 Mainfield Avenue Baltimore,Md.-21214 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery | 20c. LOCATION — City or Town, State: Baltimore,Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kathleen M. Murphy | 22. NAME AND ADDRESS OF FACILITY: John C. Miller Inc. | 6415 BElair Road Baltimore,MD.-21206 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Malignant Sarcoma | > 3yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): Its recurrence | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): N/A | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Harold [illegible] | 29c. LICENSE NUMBER: D15872 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-14-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 2220 Park Height 21208 HAROLD BOB | | |
| 31. DATE FILED (Month, Day, Year): APR 18 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davison-Lindsay | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 10940

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Francis Thomas Guercio | | 2. DATE OF DEATH (Month, Day, Year): 4-12-89 | 3. TIME OF DEATH: 7:50AM M |
| 4. SOCIAL SECURITY NUMBER: 220-20-1469 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 61 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): Sept.16,1927 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Glen Arm | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 4302 Long Green Rd. | 10f. ZIP CODE: 21057 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): 3 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Supervisor | 16b. KIND OF BUSINESS/INDUSTRY: Heineken Brewery | |
| 17. FATHER'S NAME (First, Middle, Last): Salvatore J. Guercio | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie A. Pfeiffer | | |
| 19a. INFORMANT'S NAME (Type/Print): Ellen N. Guercio | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 | | |
| 20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St.John's Long Green 4/15/89 | 20c. LOCATION — City or Town, State: Hydes, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wallace S. Brooks, Jr. | 22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple injuries | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 4-12-89 | 28b. TIME OF INJURY: 6:30 M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: Driver in auto/auto collision |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): road | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Hollins Ferry Road/695 |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle, Jr. M.D. | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-12-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr., M.D. 111 Penn Street, Baltimore, MD 21201 VC | | |
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall | |

DHMH-16 Rev 1/89

83 10ATO

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 10941 — REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Charles Gunther — CHARLES MICHAEL GUNTHER | | | 2. DATE OF DEATH (Month, Day, Year): 4-15-89 | 3. TIME OF DEATH: 1054 M |
| 4. SOCIAL SECURITY NUMBER: 213-38-8069 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 45 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5/15/43 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Home 3007 Erdman Ave | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md 21213 | | 9c. COUNTY OF DEATH: -- |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: -- | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3007 Erdman Ave | | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: PEACETIME | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4 or 5+): -- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self-employed | 16b. KIND OF BUSINESS/INDUSTRY: House Painter | |
| 17. FATHER'S NAME (First, Middle, Last): John Gunther | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Edna Lupus | |
| 19a. INFORMANT'S NAME (Type/Print): John Gunther - Father | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3007 Erdman Avenue, Balto, Md. 21213 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PARKWOOD CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brian D. Luis | 22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME 3331 Brehms Lane, Balto, Md. 21213 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Lung Cancer | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Metastases to Liver, Spleen and Skull | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 26d. DESCRIBE HOW INJURY OCCURED |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Dorothy A Snow Physician | 29c. LICENSE NUMBER: D24149 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/17/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dorothy A. Snow 3900 Loch Raven Blvd Baltimore, Md 21201 | | |
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall | |

DHMH-16 Rev 1/89

89 1091

89 10942

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): John E. Gunther | | | | 2. DATE OF DEATH (Month, Day, Year): 4 / 8 / 89 | 3. TIME OF DEATH: 655 A M |
| 4. SOCIAL SECURITY NUMBER: 212-24-8805 | 5. SEX: 1 ☐ M 2 ☐ F | 6. AGE (In yrs. last birthday): 60 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 05/14/28 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): University Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Morrell Park | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3105 Ottawa Avenue | | 10f. ZIP CODE: 21230 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: 1947-1951 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electrician | 16b. KIND OF BUSINESS/INDUSTRY: A.A. Co. Govt. | |
| 17. FATHER'S NAME (First, Middle, Last): William H. Gunther | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine Ruffner | |
| 19a. INFORMANT'S NAME (Type/Print): Pauline E. Gunther | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3105 Ottawa Avenue, Morrell Park, MD 21230 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Cemetery | 20c. LOCATION — City or Town, State: Dorsey, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph J. Ambrosa, Jr | | 22. NAME AND ADDRESS OF FACILITY: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD 21227 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiovascular Failure / Collapse | ~12 hrs |
| DUE TO (OR AS A CONSEQUENCE OF): | b. Severe Coronary Artery Disease | Several Years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): | c. Atherosclerosis of Vasculature | |
| | d. HTN, DM, and Smoking x 45 years | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Thrombocytopenia, Severe Metabolic Acidosis & Refractory to txt.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): N/A | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED: N/A |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Elaine James MD | 29c. LICENSE NUMBER: | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/8/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Elaine James MD | | |
| 31. DATE FILED (Month, Day, Year): APR 13 1989 | 32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 10943

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): ALBERT C. GAINES

**2. DATE OF DEATH** (Month, Day, Year): 4 14 89

**3. TIME OF DEATH**: M

**4. SOCIAL SECURITY NUMBER**: 218-05-9680

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 69 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 12 9 1919

**8. BIRTHPLACE** (State or Foreign Country): Md

**9a. FACILITY NAME** (If not institution, give street and number): 3840 Reisterstown Rd.

**9b. CITY, TOWN OR LOCATION OF DEATH**: Balto.

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 [X] YES 2 [ ] NO

**10e. STREET AND NUMBER**: 3840 Reisterstown Road

**10f. ZIP CODE**: 21215

**10g. CITIZEN OF WHAT COUNTRY?**: U S A

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: Black

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): ___ College (1-4 or 5+): ___

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.):

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): Clarance Johnson

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Sophie Toyer

**19a. INFORMANT'S NAME** (Type/Print): Elsie Bias

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3840 Reisterstown Road Baltimore, Md 21215

**20a. METHOD OF DISPOSITION**: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) ___

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Garrison Forest Vet Cemetery

**20c. LOCATION — City or Town, State**: Owings Mills, Md

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Jerome H. Thompson

**22. NAME AND ADDRESS OF FACILITY**: March F/H West, 4300 Wabash Avenue

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

**IMMEDIATE CAUSE (Final disease or condition resulting in death)** →
a. CONGESTIVE HEART FAILURE

DUE TO (OR AS A CONSEQUENCE OF):
b. MYOCARDIAL INFARCTION

**Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST**

DUE TO (OR AS A CONSEQUENCE OF):
c. CORONARY ARTERY DISEASE

DUE TO (OR AS A CONSEQUENCE OF):
d. CORONARY ARTERIES BY PASS GRAFT

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

CHRONIC LYMPHOCYTIC LEUKEMIA
INSULIN DEPENDENT DIABETES MEL.
PNEUMONIA

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [X] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [X] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [X] YES 2 [ ] NO

**26. PLACE OF DEATH** (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year):

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**:

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify):

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one):
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Ambachew Woreta MD

**29c. LICENSE NUMBER**: D31905

**29d. DATE SIGNED** (Month, Day, Year): ▶ 4/15/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): AMBACHEW WORETA, 2431 MARYLAND AVE BALTO MD 21218

**31. DATE FILED** (Month, Day, Year): APR 20 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-16 Rev 1/89

83 10873

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 10944
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Eula GARNER | | | | 2. DATE OF DEATH (Month, Day, Year): 4 3 89 | 3. TIME OF DEATH: 4:58 A M |
| 4. SOCIAL SECURITY NUMBER: 244 12 0284 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 67 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): NOV. 16, 1921 | 8. BIRTHPLACE (State or Foreign Country): NORTH CAROLINA |
| 9a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 7600 CLAYS LANE | | 10f. ZIP CODE: 21207 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. of A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 - 11; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RETIRED HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: HOMEMAKER |
| 17. FATHER'S NAME (First, Middle, Last): ROBERT JOYNER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY ANDERSON | |
| 19a. INFORMANT'S NAME (Type/Print): REV. HENRY COOK | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5503 FERNPARK AVENUE BALTIMORE, MARYLAND 21207 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): EASTVIEW MEMORIAL PARK 3/7/89 | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND 21224 |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lewis T Gwynn | | 22. NAME AND ADDRESS OF FACILITY: LEWIS T. GWYNN FUNERAL HOME 21215 - 6393 4517 PARK HEIGHTS AVE. BALTIMORE, MARYLAND | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiogenic Shock
DUE TO (OR AS A CONSEQUENCE OF):
b. Acute Myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):
c. A. S. C. V. D
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Peripheral vascular disease

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: DSalujaMD | 29c. LICENSE NUMBER: D17537 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-3-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DARSHAN S SALUJA | | |
| 31. DATE FILED (Month, Day, Year): APR 5 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 10945

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Margaret Koudelka Gey / Margaret K. Gey
2. DATE OF DEATH (Month, Day, Year): 4-17-89
3. TIME OF DEATH: 1235 PM
4. SOCIAL SECURITY NUMBER: 220-30-4185
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 89 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4-16-1900
8. BIRTHPLACE (State or Foreign Country): Wisconsin
9a. FACILITY NAME (If not institution, give street and number): Keswick Home
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: -------

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6017 Lakeview Road
10f. ZIP CODE: 21210
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Med. Lab Tech
16b. KIND OF BUSINESS/INDUSTRY: Cancer Research
17. FATHER'S NAME (First, Middle, Last): John Koudelka
18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Finney
19a. INFORMANT'S NAME (Type/Print): Frances G. Greene
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 109 Westdale Court Lutherville, MD 21093
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Security Process, Inc.
20c. LOCATION — City or Town, State: Catonsville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: Cremation Society of MD, Baltimore, Maryland 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: M. Isabelle MacGregor MD
29c. LICENSE NUMBER: D13657
29d. DATE SIGNED (Month, Day, Year): ▶ April 17, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M. ISABELLE MACGREGOR MD, KESWICK, 700 W 40th Street, Balto. Md 21211
31. DATE FILED (Month, Day, Year): APR 21 1989
32. REGISTRAR'S SIGNATURE: Julia Dinson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 10#2

1. FOR STATE REGISTRAR Item # 4 Film 650 per FH DD

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 10946
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages ___ should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): John J. Gibson | | | 2. DATE OF DEATH (Month, Day, Year): 4 4 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 224-20-3185 | 5. SEX: 1 M 2 F | 6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7/22/24 | 8. BIRTHPLACE (State or Foreign Country): VA. |
| 9a. FACILITY NAME (If not institution, give street and number): 1800 KAROW COURT | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| 10e. STREET AND NUMBER: 1800 KAROW COURT | | 10f. ZIP CODE: 21237 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 Never Married 2 X Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DISABLED | | 16b. KIND OF BUSINESS/INDUSTRY: NA |
| 17. FATHER'S NAME (First, Middle, Last): JOHN W. GIBSON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ADDIE PENDLETON | | |
| 19a. INFORMANT'S NAME (Type/Print): OLLIE LEE CROMER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1108 NORTH APPLETON ST./BALTIMORE, MD. 21217 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOUNT ZION CEMETERY | | 20c. LOCATION — City or Town, State: LANSDOWNE, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Julia R. March | | 22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. cardiopulmary arrst (suspected) | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. coronary arty disease, COPD, | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. HTN, Diabetes, gout | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SP CVA
DJD
colonic diverti

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA; OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | |
| 27. MANNER OF DEATH: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 X Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 YES 2 NO; 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Michael Luhar | 29c. LICENSE NUMBER: D 24393 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/5/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M. Luhar, 2000 Odell Ave, Balto, MD 21237 | | |
| 31. DATE FILED (Month, Day, Year): APR 7 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 10947
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ALEXANDER ALEXANDER GLAGOLA | | | | 2. DATE OF DEATH: MONTH 4 DAY 10 YEAR 89 | 3. TIME OF DEATH: 3:45 A M |
| 4. SOCIAL SECURITY NUMBER: 206-05-0302 A | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 71 yrs. YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 4-18-1917 | 8. BIRTHPLACE (State or Foreign Country): PA. |
| 9a. FACILITY NAME (If not institution, give street and number): GOOD SAMARITAN HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: - | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3730 Elmora Avenue | | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: 1945-1947 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Steel Worker | 16b. KIND OF BUSINESS/INDUSTRY: Beth Steel | |
| 17. FATHER'S NAME (First, Middle, Last): Demeter Glagola | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Sophia Gala | |
| 19a. INFORMANT'S NAME (Type/Print): Ruth Glagola | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3730 Elmora Avenue, Balto., Md. 21213 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery | 20c. LOCATION — City or Town, State: Balto., Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md 21213 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. GONGRENE @ TOE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DIABETES MELLITUS, PVD | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. CARDIOMYOPATHY, CHF | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. HTN | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MARIA ALAVES M.D | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4-10-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 11 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 10948

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Alexander C. Gosnell | | | 2. DATE OF DEATH (Month, Day, Year): 04 01 89 | 3. TIME OF DEATH: 20:15 M |
| 4. SOCIAL SECURITY NUMBER: 212 01 2182 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Aug. 9, 1915 | 8. BIRTHPLACE (State or Foreign Country): Balto Md |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: Balto City |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: - | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 4501 Woodlea Ave. | | 10f. ZIP CODE: 21206 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Painter-Foreman | 16b. KIND OF BUSINESS/INDUSTRY: Areo-Space | |
| 17. FATHER'S NAME (First, Middle, Last): Lawrence Gosnell | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Laura Berger | |
| 19a. INFORMANT'S NAME (Type/Print): Fred Foerster | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7931 Roxbury Dr. Glen Burnie, Md. 21061 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Pk | 20c. LOCATION — City or Town, State: Balto. Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. Balto., Md. 21221 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. [redacted] RT. HIP FRACTURE | 5 DAYS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. < OPD | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. ALCOHOL ABUSE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DEMENTIA | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 3-20-89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: FALL AT HOME |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 4501 Woodley Avenue | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Raymond A. W. Wittstadt MD | 29c. LICENSE NUMBER: | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-2-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAYMOND A. WITTSTADT UNION MEMORIAL HOSPITAL, BALTIMORE, MD | | |
| 31. DATE FILED (Month, Day, Year): APR 4 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 and 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 10949

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Patricia D. Gray | | 2. DATE OF DEATH (Month, Day, Year): April 6 1989 | 3. TIME OF DEATH: 7 34 AM |
| 4. SOCIAL SECURITY NUMBER: 125-32-2317 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 46 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 6/12/42 |
| 8. BIRTHPLACE (State or Foreign Country): Bronx, N.Y. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital Baltimore | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: Md | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2416 Loyola North Way | | 10f. ZIP CODE: 2215 | 10g. CITIZEN OF WHAT COUNTRY?: US |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales Person | 16b. KIND OF BUSINESS/INDUSTRY: Clothing Store | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Lee Gray | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Irene Corston | |
| 19a. INFORMANT'S NAME (Type/Print): Joyce Fields | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 911 Marlow Drive Bel Air Md. 21234 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery 4/11/89 | 20c. LOCATION — City or Town, State: Landsdowne, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Rodney I. Sykes | 22. NAME AND ADDRESS OF FACILITY: RODNEY I. SYKES FUNERAL SERVICE OFFICE: 4644 PIMLICO ROAD BALTIMORE MD 21215 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Arrest | 2 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Cerebral Hemorrhage with DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. herniation DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/6/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Patricia Gail Roberts, MD Resident Sinai Hospital | | |
| 31. DATE FILED (Month, Day, Year): APR 11 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 10950
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): John Graves | | | 2. DATE OF DEATH (Month, Day, Year): April 02 1989 | 3. TIME OF DEATH: 9:15 AM M |
| 4. SOCIAL SECURITY NUMBER: 212075996 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 82 (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9-8-06 | 8. BIRTHPLACE (State or Foreign Country): Indiana |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Maryland |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 464 Cummings Ct. | | 10f. ZIP CODE: 21201 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 8+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): James White | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Graves |
| 19a. INFORMANT'S NAME (Type/Print): Mrs Lorraine Martin | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 464 Cummings Ct Balto Md 21201 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt Auburn Cem | 20c. LOCATION — City or Town, State: Balto, Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph L. Russ | 22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ F.H. 2222 W. North Ave Balto. Md 21216 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Congestive Cardiac Failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Chronic Obstructive Pulmonary Disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER: N/A | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/2/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Al* Talib Khalid 827 Linden Ave. | | |
| 31. DATE FILED (Month, Day, Year): APR 5 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

89 10951

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|
| Emma Irene Grempler | 4 / 4 / 89 | approx 2:30 PM |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220449443 | 1 ☐ M 2 ☒ F | 92 YRS. | | | 01-15-1897 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Union Memeorial Hospital | Baltimore City | -- |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | - - - - | Baltimore City | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 2914 E. Cold Spring Lane | 21214 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 8 | | Homemaker | -, --- |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| William J. Brunner | Annie Hanssen |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Richard H. Schroeder | 4604 Hampnett Ave. Balto. Md. 21214 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Druid Ridge Cemetery | Baltimore, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ | Cvach Funeral Home Inc. 1211 Chesaco Ave. Balto. Md. 21237 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Possible Myocardial Infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Hypertensive Cardiovascular Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Donato A. Vargas, Jr. | 21748 | ▶ 4-5-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DONATO A. VARGAS, JR 4706 Hampnett Rd, Balto, MD 21214.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 5 1989 | Gina Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 10952
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HELEN MARIE HARSHMAN | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 25, 1989 | 3. TIME OF DEATH: 2:45 P M |
| 4. SOCIAL SECURITY NUMBER: 214-34-9277 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): April 4, 1908 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Frederick | 10c. CITY, TOWN OR LOCATION: Myersville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 12003 Wolfsville Road | | 10f. ZIP CODE: 21773 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home |
| 17. FATHER'S NAME (First, Middle, Last): Faris Smith | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Estella Leatherman | |
| 19a. INFORMANT'S NAME (Type/Print): Richard L. Harshman | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12808 Loy Wolfe Rd., Myersville, MD 21773 | |
| 20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Mark's Lutheran Cemetery | 20c. LOCATION — City or Town, State: Wolfsville, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Patty L Ricketts | | 22. NAME AND ADDRESS OF FACILITY: Ricketts Funeral Home 504 Main St. Myersville, MD 21773 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute myocardial infarction | 2 weeks |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Coronary atherosclerosis | 10 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M.D. | 29c. LICENSE NUMBER: D30948 | 29d. DATE SIGNED (Month, Day, Year): 4/25/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Johns Hopkins Hospital 601 N. Broadway Baltimore, MD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 21 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 10953

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EMMA HENRY | | | 2. DATE OF DEATH (Month, Day, Year): 4 27 89 | 3. TIME OF DEATH: 6:35 P M |
| 4. SOCIAL SECURITY NUMBER: 182-20-5883 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 98 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5-17-1890 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Maryland |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 409 Roundview Road | | 10f. ZIP CODE: 21225 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): William Gumby | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Jones |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Elizabeth Hall | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 409 Roundview Rosd, Balto. MD 21225 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rolling Green Mem. Pk. 5-2-89 | 20c. LOCATION — City or Town, State: West Chester, PA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ | 22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home 2222-26 West North Av., Balto., MD | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive Heart Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): Cerebral Vascular Accident | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): Renal Failure | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mark Pennington MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 4-27-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mark Pennington Harbor Hospital Center | | |
| 31. DATE FILED (Month, Day, Year): MAY 8 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 10954

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ANDREW steven Hook | | | 2. DATE OF DEATH (Month, Day, Year): 4 4 89 | 3. TIME OF DEATH: 4:45 P M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS / DAYS 2 — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 4-2-89 | 8. BIRTHPLACE (State or Foreign Country): Ann Arundel Hosp |
| 9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER | | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
| — | | |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): William Hook. | 18. MOTHER'S NAME (First, Middle, Maiden Surname): WENDY Hook. |
| 19a. INFORMANT'S NAME (Type/Print): AFSANEH HESSAMFAR | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): mercy Hosp. 301 St. Paul Place Baltimore 21202 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in-state removal | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. cardiorespiratory arrest. | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. severe immaturity — DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Hyaline membrane disease — DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Afsaneh Hessamfar MD. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/4/89. |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mercy Hosp. 301 St. Paul Place. Baltimore. MD 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 09 1989 | 32. REGISTRAR'S SIGNATURE: Lucia Davidson-Randall |

DHMH-16 Rev 1/89

89 10955

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

Ed

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Edward T. Holt | | | | | 2. DATE OF DEATH (Month, Day, Year): April 27 1989 | | 3. TIME OF DEATH: 0120 AM |
| 4. SOCIAL SECURITY NUMBER: 220-18-4663 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 61 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3/3/28 | | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2324 IVY AVENUE | | 10f. ZIP CODE: 21214 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): AIR FORCE | 16b. KIND OF BUSINESS/INDUSTRY: RETIRED | |
| 17. FATHER'S NAME (First, Middle, Last): JOHN HOLT | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): FLORENCE DEW | |
| 19a. INFORMANT'S NAME (Type/Print): Adell Holt | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2324 IVY AVENUE/Baltimore, MD. 21214 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VA. CEMETERY | 20c. LOCATION — City or Town, State: OWINGS MILLS, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warner | | 22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIAC ARREST | Ø |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CEREBROVASCULAR ACCIDENT - BRAINSTEM INFARCT | one wk. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PNEUMONIA; RESPIRATORY FAILURE, ARREST; HYPERTENSION, DIABETES MELLITUS (Adult-onset)

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Meredith Anthony MD | 29c. LICENSE NUMBER: Md. D37717 | 29d. DATE SIGNED (Month, Day, Year) ▶ April 27, 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MEREDITH R. ANTHONY, MD. | | |
| 31. DATE FILED (Month, Day, Year): MAY 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Ritchie | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 10956
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 & 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GEORGE E HARTMAN JR. | | | | | 2. DATE OF DEATH (Month, Day, Year): 4 26 89 | 3. TIME OF DEATH: 5:50 P M |
| 4. SOCIAL SECURITY NUMBER: 219-30-2516 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 53 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 7-23-35 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Balto. City | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore City | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2257 Sidney Avenue | | 10f. ZIP CODE: 21230 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Warehouseman | 16b. KIND OF BUSINESS/INDUSTRY: Food Industry | |
| 17. FATHER'S NAME (First, Middle, Last): George E. Hartman Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lenora M. Sonnenleiter | |
| 19a. INFORMANT'S NAME (Type/Print): Beverly Hartman | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2257 Sidney Avenue Baltimore, Md. 21230 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Brooklyn, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard C Owens | | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. OBSTRUCTIVE LUNG DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Marian Fong Benner Home Myer | D37693 | ▶ 4-26-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARIAN FONG BENNER 3001 S. HANOVER ST BALTO. MD 21230

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 1 _ 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 10957

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROSE HUDSON | | 2. DATE OF DEATH (Month, Day, Year): 04 29 89 | 3. TIME OF DEATH: 6:30 AM |
| 4. SOCIAL SECURITY NUMBER: Unavailable | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 59 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 4/18/30 |
| 8. BIRTHPLACE (State or Foreign Country): Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Lincoln Conv. Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 319 S. Gilmore Street | 10f. ZIP CODE: 21223 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): William Bush | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Fannie Sizemore | | |
| 19a. INFORMANT'S NAME (Type/Print): Susan Turner | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 319 S. Gilmore Street Baltimore, Md. 21230 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Cemetery | 20c. LOCATION — City or Town, State: Middle River, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Teresa L Goff | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Severe COPD. | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Hyponatremia | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: A. I. Baykaler, MD | 29c. LICENSE NUMBER: D0203 1 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-29-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. I. BAYKALER, M.D 831 Poplar Grove St. Bal. Md. 21216 | | |
| 31. DATE FILED (Month, Day, Year): MAY 4 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DNMH-16 Rev 1/89

89 10951

89 10958

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HOLMES / CURTIS / HOPKINS | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 18, 1989 | 3. TIME OF DEATH: 11:20P M |
| 4. SOCIAL SECURITY NUMBER: 578-10-0707 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): March 10, 1917 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Upper Marlboro | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: Post Office Box 546 | | 10f. ZIP CODE: 20772 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: 5/14/45----11/24/45 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): (12); College (1-4 or 5+): None | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bail Bondsman | 16b. KIND OF BUSINESS/INDUSTRY: Own Business | |
| 17. FATHER'S NAME (First, Middle, Last): William Curtis Hopkins | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Hannah ----- Smith | |
| 19a. INFORMANT'S NAME (Type/Print): Laura Anderson Hopkins | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Post Office Box 546, Upper Marlboro, Md. 20772 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Trinity Cemetery | 20c. LOCATION — City or Town, State: Upper Marlboro, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard A. Coleman | | 22. NAME AND ADDRESS OF FACILITY: Richard A. Coleman Funeral Home, Upper Marlboro, Maryland 20772 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Diffuse Carcinomatosis | 1 month |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Pancreatic Carcinoma | 6 months |
| DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M. Armeni MD | 29c. LICENSE NUMBER: P-03093 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/19/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M. ARMENI Johns Hopkins Hospital | | |
| 31. DATE FILED (Month, Day, Year): APR 26 1989 | 32. REGISTRAR'S SIGNATURE: [illegible] | |

ONMN-16 Rev 1/89

89 10328

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 10959
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Delilah Harris
2. DATE OF DEATH (Month, Day, Year): 4 24 89
3. TIME OF DEATH: 2:30? M
4. SOCIAL SECURITY NUMBER: 222-05-3333
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9-7-14
8. BIRTHPLACE (State or Foreign Country): N. C
9a. FACILITY NAME (If not institution, give street and number): Bon Secours Hospital 2000 N Baltimore St.
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore Maryland
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2659 W. Lafayette Ave
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Thom Spence
18. MOTHER'S NAME (First, Middle, Maiden Surname): Hattie Harvey
19a. INFORMANT'S NAME (Type/Print): Frederick Parker
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2659 W. Lafayette Ave
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Eastview Mem Park
20c. LOCATION — City or Town, State: Balto, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dale March
22. NAME AND ADDRESS OF FACILITY: March Funeral Home 4300 Wabash Ave

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Pages 1, 2, 3 should be detached by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CHF | |
| DUE TO (OR AS A CONSEQUENCE OF): | b. ARRYTHMIA | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): c. DIABETES | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. HBP | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CANCER OF BOWEL

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mark Ommo
29c. LICENSE NUMBER: D23760
29d. DATE SIGNED (Month, Day, Year): ▶ 4/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARK ONIS M.D 9141 BANTAM Rice Ellicott City Md 21043
31. DATE FILED (Month, Day, Year): APR 27 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Lockett

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 10960

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MD 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be [illegible] hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [illegible] used for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HARRIS ALBERT ALBERT HARRIS | | | 2. DATE OF DEATH MONTH 4 DAY 23 YEAR 89 | 3. TIME OF DEATH 0530 M |
| 4. SOCIAL SECURITY NUMBER: 215-05-3860 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 93 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5-2-95 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MD. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 501 W. FRANKLIN STREET | | 10f. ZIP CODE: 21201 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WWII. | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5 +) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER | | 16b. KIND OF BUSINESS/INDUSTRY: Olin Mathieson Chemical Co. |
| 17. FATHER'S NAME (First, Middle, Last): Patrick Harris | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Carroll | | |
| 19a. INFORMANT'S NAME (Type/Print): Harrison L. Day | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 401 Severna Park Md 21146 | | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crownsville Veterans Cem | 20c. LOCATION — City or Town, State: Crownsville, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Maria Adams Jones | | 22. NAME AND ADDRESS OF FACILITY: Marshall W. Jones, Jr Funeral Home 4101 Edmondson Ave 21229 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ✱ METASTATIC CANCER OF STOMACH

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Cancer of Stomach | 3yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sepsis + Pneumonia SEPSIS&PNEUMONIA

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: J. Punzalan MD | 29c. LICENSE NUMBER: D15124 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/23/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 5214 Harford rd. Balt. md. | DR J. PUNZALAN 7214 | |
| 31. DATE FILED (Month, Day, Year): APR 27 1989 | 32. REGISTRAR'S SIGNATURE: Barbara Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 10961

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WILLIAM C. HALL | | | 2. DATE OF DEATH (Month / Day / Year): 04 / 22 / 1989 | 3. TIME OF DEATH: 2:50 AM |
| 4. SOCIAL SECURITY NUMBER: 216-24-8480 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 59 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 6/10/29 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1244 BROADWAY | | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 8+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DISABLED | 16b. KIND OF BUSINESS/INDUSTRY: NA |
| 17. FATHER'S NAME (First, Middle, Last): FRANK HALL | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): VIOLA NORTHERN | |
| 19a. INFORMANT'S NAME (Type/Print): GLENDA HALL | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1244 BROADWAY/BALTO., MD 21213 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vanessa Davis | | 22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Lung CANCER | 6 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): On Colozy Center 3N Johns Hop Hosp | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Balto., Md. | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Louis A Salas MD. | 29c. LICENSE NUMBER: # D37913 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/22/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Louis A. Salas M.D 600 N. Wolfe St.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 25 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

12

89 10961

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 10962

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

2

3

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): STEPHEN JAY HALPERN

**2. DATE OF DEATH** Month: 4 Day: 24 Year: 89

**3. TIME OF DEATH**: 6:40P M

**4. SOCIAL SECURITY NUMBER**: 161-36-3143

**5. SEX**: 1 ☒ M 2 ☐ F

**6. AGE** (In yrs. last birthday): 41 YRS. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

**7. DATE OF BIRTH** (Month, Day, Year): NOV. 5, 1947

**8. BIRTHPLACE** (State or Foreign Country): PENNSYLVANIA

**9a. FACILITY NAME** (If not institution, give street and number): SINAI HOSP OF BALTO.

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTO.

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: BALTIMORE

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 3008 KFALLSTAFF MANOR CT

**10f. ZIP CODE**: 21209

**10g. CITIZEN OF WHAT COUNTRY?**: US

**11. MARITAL STATUS**: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: XX

**14. RACE — American Indian, Black, White, etc.** Specify: WHITE

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 1

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): CHAUFFEUR

**16b. KIND OF BUSINESS/INDUSTRY**: TAXI CAB

**17. FATHER'S NAME** (First, Middle, Last): MARTIN E. HALPERN

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): SOPHIE RETTER

**19a. INFORMANT'S NAME** (Type/Print): RICHARD E. HALPERN

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6614 DEANCROFT RD. BALTO., MD 21209

**20a. METHOD OF DISPOSITION**: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): LOUDON PARK CREMATORY

**20c. LOCATION — City or Town, State**: BALTIMORE, MD

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Sydney L Stellman

**22. NAME AND ADDRESS OF FACILITY**: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIO RESPIRATORY ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): BRAIN DEATH | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): CRYPTOCOCCAL MENINGITIS | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HIV (+)

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year):

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**:

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify):

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one):
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**:

**29c. LICENSE NUMBER**: HOUSESTAFF

**29d. DATE SIGNED** (Month, Day, Year): 4/24/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): CHERYL TAYLOR SINAI HOSP, BALT

**31. DATE FILED** (Month, Day, Year): APR 27 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Parker

DNMH-16 Rev 1/89

HOWARD, FRANK

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 10963 REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Frank Howard | | | | 2. DATE OF DEATH (Month, Day, Year): 4/29/89 | | | 3. TIME OF DEATH: 4:00 A M |
| 4. SOCIAL SECURITY NUMBER: 220-03-1973 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 77 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1/1/12 | | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): LOCH RAVEN VA HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO | |
| 10e. STREET AND NUMBER: 1010 McKEAN AVENUE | | | 10f. ZIP CODE: 21217 | | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RUBBER MAKER | | | 16b. KIND OF BUSINESS/INDUSTRY: CATS PAW | |
| 17. FATHER'S NAME (First, Middle, Last): SOLOMON HOWARD | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSA CLARK | | | |
| 19a. INFORMANT'S NAME (Type/Print): RUTH HOWARD | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1010 McKEAN AVENUE; balto. md 21217 | | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VET CEM. | | | 20c. LOCATION — City or Town, State: BALTIMORE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy A. Dyett | | | 22. NAME AND ADDRESS OF FACILITY: LEROYO. DYETT & SON F.H., INC. 4600 LIBERTY HEIGHTS AVENUE 21207 | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIAC Arrest | 20 Min |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Metabolic Acidosis | Days to Hours |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Sepsis | Week. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal failure
Liver failure
Respiratory failure

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | M | 1 [ ] YES 2 [ ] NO | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| P A DeValeria MD | | 4/29/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): P. A. DeValeria

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 2 - 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7

89 10363

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 10964
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOHN WILLIAM HOOK | | | 2. DATE OF DEATH (Month / Day / Year): 4 / 27 / 89 | 3. TIME OF DEATH: 12:27 P M |
| 4. SOCIAL SECURITY NUMBER: 216-05-5050 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 75 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 11/19/13 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: -- |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: -- | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 728 BROOKWOOD ROAD | | 10f. ZIP CODE: 21229 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DELIVERY TRUCK DRIVER | 16b. KIND OF BUSINESS/INDUSTRY: COOKIE COMPANY | |
| 17. FATHER'S NAME (First, Middle, Last): THOMAS HOOK | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): BERTHA MILLER | |
| 19a. INFORMANT'S NAME (Type/Print): VIVIAN HOOK | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 728 BROOKWOOD ROAD, BALTIMORE, MARYLAND 21229 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LORRAINE PARK CEMETERY | 20c. LOCATION — City or Town, State: WOODLAWN, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Staph. epidermatis endocarditis c vegetations | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Septic thromboembolus @ radial artery | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Cerebellar hematoma c brain stem compression | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 8 [ ] Residence 8 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Blake Kutsche MD | 29c. LICENSE NUMBER: D-35788 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): B. KUTSCHE ST. AGNES HOSPITAL 900 CATON AVE. BALTIMORE, MD 21229

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 10965
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ronald V. (Harly) Harley
2. DATE OF DEATH (Month, Day, Year): 4 25 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 212-48-0480
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 41 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 1 9 1948
8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): 3929 Bonner Rd.
9b. CITY, TOWN OR LOCATION OF DEATH: Balto.
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3929 Bonner Road
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.):
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Emmett Fowlkes
18. MOTHER'S NAME (First, Middle, Maiden Surname): Gertrude Garley
19a. INFORMANT'S NAME (Type/Print): Gertrude Fowlkes
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4410 Pall Mall Road Apt 2 C Baltimore, Md
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Westview Memorial Park
20c. LOCATION — City or Town, State: Catonsville, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dale March
22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Ave.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | LIVER FAILURE | 1 month |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | DISSEMINATED CRYTOCOCCUS | 6 mos |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | AIDS | years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Michael A. Martin MD
29c. LICENSE NUMBER: D37077
29d. DATE SIGNED (Month, Day, Year): 4/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL A. MARTIN, UNIV OF MD HOSPITAL
31. DATE FILED (Month, Day, Year): MAY 4 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

89 10962

89 10966

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ALBERT HARRIS | | 2. DATE OF DEATH (Month, Day, Year): APRIL 28, 1989 | 3. TIME OF DEATH: 3:30 A a M |
| 4. SOCIAL SECURITY NUMBER: 219-66-5834 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 34 YRS. (If under 1 year: Months/Days; If under 24 hrs.: Hours/Min.) | 7. DATE OF BIRTH (Month, Day, Year): 1 8 1955 |
| 8. BIRTHPLACE (State or Foreign Country): MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number): MARYLAND GENERAL HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: BALTIMORE CITY | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 4900 CRENSHAW AVENUE | 10f. ZIP CODE: 21206 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. | |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SECURITY GUARD | 16b. KIND OF BUSINESS/INDUSTRY: BROADWAY SERVICES |
| 17. FATHER'S NAME (First, Middle, Last): RICHARD E. RANDOLPH, JR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ETHEL MAE HARRIS | |
| 19a. INFORMANT'S NAME (Type/Print): RICHARD & ETHEL MAE RANDOLPH | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2615 E. OLIVER STREET, BALTIMORE, MD. 21203 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): E BALTIMORE CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary L. Rollins | | 22. NAME AND ADDRESS OF FACILITY: NUTTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ACQUIRED IMMUNE DEFICIENCY SYNDROME | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RESPIRATORY FAILURE
BILATERAL PNEUMONIA
ANOXIC ENCEPHALOPATHY

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: [XX] 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Stephen Lopez M D | 29c. LICENSE NUMBER: 04008 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/28/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stephen Lopez, M.D. c/o Maryland General Hospital

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 4 - 1989 | 32. REGISTRAR'S SIGNATURE: Gene Harrison-Randall |

DHMH-16 Rev 1/89

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Item# 4 per FH film 651 5/9/89fj

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 10967 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BYNER LOUISE HUNTER (HARVIN)
2. DATE OF DEATH (Month, Day, Year): APRIL 29, 1989
3. TIME OF DEATH: 3:00 a M
4. SOCIAL SECURITY NUMBER: 239-46-7706
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 59 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2/8/30
8. BIRTHPLACE (State or Foreign Country): S.C.
9a. FACILITY NAME (If not institution, give street and number): MARYLAND GENERAL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4517 MANNASOTA AVENUE
10f. ZIP CODE: 21206
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PERSONAL CARE AID
16b. KIND OF BUSINESS/INDUSTRY: DISABLED
17. FATHER'S NAME (First, Middle, Last): ARTHUR HARVIN
18. MOTHER'S NAME (First, Middle, Maiden Surname): BYNER SINGLETON
19a. INFORMANT'S NAME (Type/Print): VERNA SIVELLS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4517 MANNASOTA AVENUE/BALTIMORE, MD 21206
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PK. CEMETERY
20c. LOCATION — City or Town, State: ARBUTUS, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Calvin L. Williams
22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SQUAMOUS CELL CARCINOMA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SACRAL DECUBITUS
POSSIBLE SEPSIS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ken Tang MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 4/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): MAY 4 1989
32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 10968
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JAMES HILL | | | 2. DATE OF DEATH (Month / Day / Year): 04 / 10 / 89 | 3. TIME OF DEATH: 1:54 AM |
| 4. SOCIAL SECURITY NUMBER: 212-18-4159 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 73 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 9 4 1916 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): UNION MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Balto. | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1429 Eager Street | | 10f. ZIP CODE: 21205 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self Employed | 16b. KIND OF BUSINESS/INDUSTRY: Contractor | |
| 17. FATHER'S NAME (First, Middle, Last): Warren Hill | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Janie Johnson | |
| 19a. INFORMANT'S NAME (Type/Print): | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): | | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veteran Cem. | 20c. LOCATION — City or Town, State: Owings Mills, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: Jeff Miller F.H. 1634 N. Broadway | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Hyperkalemia / Hyponatremia | 1 hour |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF): | Cerebral Vascular Accident | 1 1/2 mo |
| c. DUE TO (OR AS A CONSEQUENCE OF): | ETOH Abuse | 30 yrs. |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Acute Renal Failure

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Donald C. Hamm MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/10/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DONALD C HAMM MD 201 E Univ. Pkway, Balto. MD. 21218 | | |
| 31. DATE FILED (Month, Day, Year): MAY 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Leroy Hedgeman | | | 2. DATE OF DEATH (Month, Day, Year): 4-13-89 | 3. TIME OF DEATH: 5:39PM M |
| 4. SOCIAL SECURITY NUMBER: 073-24-7580 | 5. SEX: 1 [XX] 2 [ ] F | 6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): April 1,1928 | 8. BIRTHPLACE (State or Foreign Country): New York |
| 9a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: New York | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Brooklyn | | 10d. INSIDE CITY LIMITS? 1 [XX] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 144 Hull Street | | 10f. ZIP CODE: | | 10g. CITIZEN OF WHAT COUNTRY? United States |
| 11. MARITAL STATUS: 1 [XX] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [XX] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [XX] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintenance | | 16b. KIND OF BUSINESS/INDUSTRY: Private |
| 17. FATHER'S NAME (First, Middle, Last): Unknown | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown | | |
| 19a. INFORMANT'S NAME (Type/Print): Patricia Green Niece | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 184-08 145th St. Springfield Garden,New York | | |
| 20a. METHOD OF DISPOSITION: 1 [XX] Burial 2 [ ] Cremation 3 [XX] Removal from State 4 [X] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Pine Lawn Cemetery | | 20c. LOCATION — City or Town, State: Pine Lawn,New York |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | | 22. NAME AND ADDRESS OF FACILITY: 389 Rhode Island Ave. Frazier's Funeral Home Washington,D.C. | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Pulmonary embolism and acute hemorrhagic inflammation of the genito urinary tract with uremic pericarditis

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. Prostatic Hypertrophy
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertensive arteriosclerotic cardiovascular disease,
Emphysema

24a. WAS AN AUTOPSY PERFORMED? 1 [XX] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [XX] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [XX] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [XX] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [XX] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

| 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 26d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[XX] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin MD | OCME | ▶ 4-14-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin,M.D. 111 Penn Street,Baltimore,MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 09 '89 | Julia Davidson-Randall |

5

OHMH-16 Rev 1/89

84 10369

89 10970

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached from pg. 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH F. HARTZ | | | | 2. DATE OF DEATH (Month, Day, Year): 04 29 1989 | 3. TIME OF DEATH: 7:23 PM M |
| 4. SOCIAL SECURITY NUMBER: 385-70-6965 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 28 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 08-13-60 | 8. BIRTHPLACE (State or Foreign Country): Michigan |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: S.Carolina | 10b. COUNTY: Greenville | 10c. CITY, TOWN OR LOCATION: Greenville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2207 Wade Hampton Blvd.,Apt.#C-312 | | 10f. ZIP CODE: 29614 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales Promotion | 16b. KIND OF BUSINESS/INDUSTRY: Advertising Directories |
| 17. FATHER'S NAME (First, Middle, Last): Daniel Edward Thomas | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Geraldine Cecelia VanKuiken | |
| 19a. INFORMANT'S NAME (Type/Print): Sandra Thomas | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11934 Frederick Rd.,Ellicott City,MD 21043 | |
| 20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Charles Miller Slack | | 22. NAME AND ADDRESS OF FACILITY: Slack Funeral Home P.O.Box 268;Ellicott City,MD 21043 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart felure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) → | a. Sepsis | 3 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST | b. Hepatic failure | 1 year |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Sclerosing Cholangitis | 3 years |
| | OUE TO (OR AS A CONSEQUENCE OF): | |
| | d. insulinoma | 6 years |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF OEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCUREO |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Earl Hope MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/29/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Earl Hope MD Johns Hopkins Hosp, Balto MD 21205

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 01 '89 | 32. REGISTRAR'S SIGNATURE: Lucia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 10971

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GLADYS M. HOM | | | 2. DATE OF DEATH: MONTH APRIL DAY 28 YEAR 1989 | 3. TIME OF DEATH: 3:00 A. M |
| 4. SOCIAL SECURITY NUMBER: 217-10-7140 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): MAR. 28, 1915 | 8. BIRTHPLACE (State or Foreign Country): MD. |
| 9a. FACILITY NAME (If not institution, give street and number): 2730 GUILFORD AVE. | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE MD. | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2730 GUILFORD AVE. | | 10f. ZIP CODE: 21218 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 / College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): WAITRESS | | 16b. KIND OF BUSINESS/INDUSTRY: RESTAURANT |
| 17. FATHER'S NAME (First, Middle, Last): CLARENCE BEEMAN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LULA FAZENBAKER | | |
| 19a. INFORMANT'S NAME (Type/Print): JEFF MONAHAN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2730 GUILFORD AVE. BALTIMORE MD. 21218 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GLEN HAVEN MEMORIAL PARK | 20c. LOCATION — City or Town, State: GLEN BURNIE MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edison M. Perkins Jr. | | 22. NAME AND ADDRESS OF FACILITY: HENRY W. JENKINS AND SONS CO. 4905 YORK RD. BALTO. MD. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma of Colon (Metastatic) | years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure
Chronic Renal Failure
Chronic Obstructive Lung Disease

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| 29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER: C.W. Bryan MD | 29c. LICENSE NUMBER: D16349 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/28/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C.W. BRYAN M.D. MD. GEN. HOSP. 827 LINDEN AVE BALTIMORE, MD | | |
| 31. DATE FILED (Month, Day, Year): MAY 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DNMN-15 Rev 1/89

89 1021

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 10972
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Louise Johnson Hardy

**2. DATE OF DEATH** (Month, Day, Year): 4-23-89

**3. TIME OF DEATH**: 1:05PM M

**4. SOCIAL SECURITY NUMBER**: 218-36-7306

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 86 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 1/31/1903

**8. BIRTHPLACE** (State or Foreign Country): Virginia

**9a. FACILITY NAME** (If not institution, give street and number): 2018 Mc Kean Avenue

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore City

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: Baltimore, Maryland 21217

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 2018 McKean Avenue, Baltimore, Maryland

**10f. ZIP CODE**: 21217

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**
1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☐ NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: Black

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4 or 6+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Housewife

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): Frank Johnson

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Sallie Goode Johnson

**19a. INFORMANT'S NAME** (Type/Print): Rev. Christopher Hill Jr.

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2018 McKean Avenue, Baltimore, Maryland 21217

**20a. METHOD OF DISPOSITION**
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 4/28/89

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Arbutus Memorial Park

**20c. LOCATION — City or Town, State**: Arbutus, Maryland

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**:

**22. NAME AND ADDRESS OF FACILITY**: ESTEP BROTHERS FUNERAL SERVICE,P.A.
1300 EUTAW PLACE, BALTIMORE,MD, 21217

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO
INQUIRY

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☒ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** ☒ YES 2 ☐ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**
☒ 1 Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year):

**28b. TIME OF INJURY** M:

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**:

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify):

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Margarita A. Korell

**29c. LICENSE NUMBER**: OCME

**29d. DATE SIGNED** (Month, Day, Year): ▶ 4-24-89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Margarita A. Korell,M.D. 111 Penn Street,Baltimore,Md 21201 VC

**31. DATE FILED** (Month, Day, Year): MAY 2 1989

**32. REGISTRAR'S SIGNATURE**: Gloria Davidson-Randall

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 10973

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): [illegible] Catherine Horsey
2. DATE OF DEATH: MONTH 4 DAY 18 YEAR 89
3. TIME OF DEATH: 445p M
4. SOCIAL SECURITY NUMBER: 220-20-3406
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 78 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12/27/10
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Univ Hosp ER
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1027 Cathedral #5L
10f. ZIP CODE: 21201
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker
16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): Daniel Brown
18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Parker
19a. INFORMANT'S NAME (Type/Print): Beverly A. Horsey
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1295 Thom Crt. Anna Md. 21403
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Cem
20c. LOCATION — City or Town, State: Annapolis - Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Charles E. Hicks III
22. NAME AND ADDRESS OF FACILITY: Hicks Funeral Home 1922 Forest Dr. Anna. Md. 21401

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio respir arrest | |
| | DUE TO (OR AS A CONSEDUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEDUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] Rommer
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 4/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] Rommer 225 Greene
31. DATE FILED (Month, Day, Year): MAY 04 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMN-18 Rev 1/89

89 10974

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Ronald L. Hockenberry | | | | 2. DATE OF DEATH (Month, Day, Year): 4-25-89 | 3. TIME OF DEATH: 1:00PM M |
| 4. SOCIAL SECURITY NUMBER: 189-30-7623 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 50 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | | 7. DATE OF BIRTH (Month, Day, Year): 02-08-39 | 8. BIRTHPLACE (State or Foreign Country): Pensylvania |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: Baltimore | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MD | 10b. COUNTY: Anne A rundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 7882 Americana Circle, Apt. T3 | | 10f. ZIP CODE: 21061 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1956/60 | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver | | 16b. KIND OF BUSINESS/INDUSTRY: Trucking | |
| 17. FATHER'S NAME (First, Middle, Last): Clarence Hockenberry | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Wallace | | | |
| 19a. INFORMANT'S NAME (Type/Print): Leilani F. Hockenberry | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7882 Americana Circle, Apt. T3 Glen Burnie, MD | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): National Memorial Park Maryland Veterans Cemetery | | 20c. LOCATION — City or Town, State: Laurel, Crownsville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bath J Hardesty | | 22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home P.A. Gambrills, MD | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Coronary thrombosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient [X] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) / 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-26-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. KOkes, M.D. 111 Penn Street, Baltimore, MD 21201 VC | | |
| 31. DATE FILED (Month, Day, Year): APR 27 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit ... Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

3
#3

89 10971

Items23a thu28f Per M.E. FilmG651 5/12/89 CG

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 10975

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, and 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): FLORENCE HAMPTON | | | 2. DATE OF DEATH (Month, Day, Year): 4 14 89 | 3. TIME OF DEATH: 5:17 PM |
| 4. SOCIAL SECURITY NUMBER: 218-22-6849 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 02-02-16 | 8. BIRTHPLACE (State or Foreign Country): YORK, PA. |
| 9a. FACILITY NAME (If not institution, give street and number): Bon Secours Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: BALTIMORE CITY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE CITY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 740 POPULAR GROVE STREET | | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RETIRED | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): ELMER SALISBURY | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LAURA ? | |
| 19a. INFORMANT'S NAME (Type/Print): MAE RUFUS JENKINS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4007 ARAGON AVENUE (21215) | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. ZION CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | | 22. NAME AND ADDRESS OF FACILITY: BROWN-THOMPSON F.H. P.O. BOX 4433 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple blunt force injuries with complications

DUE TO (OR AS A CONSEQUENCE OF): and anal/rectal trauma

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 4/14/89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☒ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED: Subject beaten and abused |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 740 Poplar Grove St. Balto. City Md. |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year) ▶ 4-15-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn St., Balto., MD 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 18 1989 | 32. REGISTRAR'S SIGNATURE |

DHMH-16 Rev 1/89

Item#7 Film#g651 05/26/89 per F.H. da

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

'89 10976 REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WALTER V. HURLEY, Jr.

2. DATE OF DEATH (Month, Day, Year): 04 16 89

3. TIME OF DEATH: 0528 A M

4. SOCIAL SECURITY NUMBER: 578-18-4462

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 72 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.

7. 03-10-17 ~~April 16, 1989~~

8. BIRTHPLACE (State or Foreign Country): Washington, D.C.

9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City

9c. COUNTY OF DEATH: Baltimore City

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Halethorpe

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 5838 Oakland Road

10f. ZIP CODE: 21227

10g. CITIZEN OF WHAT COUNTRY? U. S. A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: white

16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+)

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Therapist

16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): Walter V. Hurley, Sr.

18. MOTHER'S NAME (First, Middle, Maiden Surname): ~~Hope~~ Kathryn

19a. INFORMANT'S NAME (Type/Print): Eleanore S. Hurley

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5838 Oakland Rd. Halethorpe, Md. 21227

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Thomas Parish Cemetery

20c. LOCATION — City or Town, State: Upper Marbboro, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE

22. NAME AND ADDRESS OF FACILITY: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, Md. 21227

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. ... may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

22. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

a. ACUTE PERITONITIS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. PERFORATION & LEAKING AT DUODENAL-

DUE TO (OR AS A CONSEQUENCE OF):

c. JEJUNAL ANASTAMOSIS

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MYELOPROLIFERATIVE DISORDER

24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

25a. DATE OF INJURY (Month, Day, Year)

25b. TIME OF INJURY M

25c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

26d. DESCRIBE HOW INJURY OCCURED

26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael E Pelczar MD

29c. LICENSE NUMBER: D09990

29d. DATE SIGNED (Month, Day, Year): 4/16/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL E. PELCZAR M.D. ST. AGNES HOSPITAL

31. DATE FILED (Month, Day, Year): APR 20 1989

32. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

DHMH-15 Rev 1/89

15

89 10977

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DWIGHT HASKINS | | | 2. DATE OF DEATH: MONTH 4 DAY 22 YEAR 89 | 3. TIME OF DEATH: 0127 M |
| 4. SOCIAL SECURITY NUMBER: 217-54-2452 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 41 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3-3-48 | 8. BIRTHPLACE (State or Foreign Country): Baltimore, Md |
| 9a. FACILITY NAME (If not institution, give street and number): Church Home Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BaLTIMORE | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 26 S. Exeter Street | | 10f. ZIP CODE: | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): Linwood Bell | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ophelia Haskins | |
| 19a. INFORMANT'S NAME (Type/Print): Joseph Haskins, Sr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2525 Calverton Heights Balto. Md. | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Eastview Memorial Park | | 20c. LOCATION — City or Town, State: Baltimore |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy O. Dyett | | | 22. NAME AND ADDRESS OF FACILITY: Leroy O. Dyett & Son Funeral Home 4600 Libety Hghts Ave 21207 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Gram negative sepsis GRAM NEGATIVE SEPSIS | days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. | liver failure LIVER FAILURE | years |
| DUE TO (OR AS A CONSEQUENCE OF): c. | alcohol ALCOHOL | years |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Timothy J. Low M.D. TIMOTHY J. LOW MD. | MD D24034 | 4/22/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TIMOTHY J. LOW, CHURCH HOSPITAL
Timothy J. Low, Church Hospital

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 26 1989 | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 10978

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| FLORENCE | HARDMAN | April 14, 1989 | 2:30 P.M. |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-01-1041 | 1 ☐ M 2 ☒ F | 88 YRS. | | | 12/18/1900 | Washington, D.C. |

| 8a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 3600 W. Franklin Street, | Baltimore, Maryland | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | | Baltimore, Maryland | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 3600 W. Franklin Street, Apt 8-N | 21229 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO Specify: | Specify: Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | | | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Richard Henson | Bessie Henson |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Dorothy H. Brooks | 3600 W. Franklin St, Apt 8-L Baltimore, Md. 21229 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Maryland National Park, | P.G. Laurel, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ | 1300 Eutaw Place, Baltimore, Maryland Estep Brother FSPA. |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pancreatic Cancer | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | OUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 6 ☒ Residence 8 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Patricia A. Thomas | D35422 | ▶ 4-17-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Patricia A. Thomas, MD 1000 E. Eager St. Baltimore, MD 21202

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 20 1989 | Julia Davidson-Landale |

DHMH-16 Rev 1/89

89 1078

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 10979
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Edith V. Harrah
2. DATE OF DEATH (Month, Day, Year): April 21, 89
3. TIME OF DEATH: 7:35 P M
4. SOCIAL SECURITY NUMBER: 230-32-0373
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 78 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-24-10
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: --
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2301 Tacoma St.
10f. ZIP CODE: 21230
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machine operator
16b. KIND OF BUSINESS/INDUSTRY: Liquor plant
17. FATHER'S NAME (First, Middle, Last): Lester Norman
16. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Tillman
19a. INFORMANT'S NAME (Type/Print): Conny C. Prince
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2301 Tacoma Street Baltimore, MD 21230
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery
20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶
22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ASPIRATION PNEUMONIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 8 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph Quint MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year) ▶ 4/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSEPH QUINT MD, ST AGNES HOSP. 900 CATON AVE. BALTO MD. 21227
31. DATE FILED (Month, Day, Year): APR 24 1989 Julia
32. REGISTRAR'S SIGNATURE: Barbara Lindsay

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 10980
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Wilbert Lawrence Harris | | | 2. DATE OF DEATH (Month, Day, Year): 4 / 12 / 89 | 3. TIME OF DEATH: 9:30 am M |
| 4. SOCIAL SECURITY NUMBER: 223-42-0707 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 56 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2-3-33 | 8. BIRTHPLACE (State or Foreign Country): VA |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore MD | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2548 E. Eager St | | 10f. ZIP CODE: 21205 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Disabled | 16b. KIND OF BUSINESS/INDUSTRY: NA | |
| 17. FATHER'S NAME (First, Middle, Last): Edgar Harris | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Cora V. Harris | |
| 19a. INFORMANT'S NAME (Type/Print): Fran Harris | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2548 E. Eagar ST. / Balto. MD. 21205 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Mem. Park | 20c. LOCATION — City or Town, State: Arbutus, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard Gaitto | 22. NAME AND ADDRESS OF FACILITY: William C. March Funeral Home 1101 E. North Avenue 21202 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. possible pulmonary embolus | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. also, electromechanical dissociation | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GI bleed

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D08547 | 29d. DATE SIGNED (Month, Day, Year): 4/12/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ANNE M. STOLINE, MD FSK MEDICAL CENTER | | |
| 31. DATE FILED (Month, Day, Year): APR 14 1989 | 32. REGISTRAR'S SIGNATURE: Jicha Davidson-Randese | |

DHMH-16 Rev 1/89

83 1080

89 10981

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NONA M. HARRIS
2. DATE OF DEATH: MONTH 4 DAY 12 YEAR 89
3. TIME OF DEATH: 1:36 P M
4. SOCIAL SECURITY NUMBER: 212-05-6286
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2-11-04
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): ST. JOSEPH HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE CO.
10c. CITY, TOWN OR LOCATION: PARKVILLE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3114 WILLOUGHBY ROAD
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): —
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOME MAKER
16b. KIND OF BUSINESS/INDUSTRY: —
17. FATHER'S NAME (First, Middle, Last): WILLIAS S. McCLAIN
18. MOTHER'S NAME (First, Middle, Maiden Surname): VIOLA BLANCHE McCLAIN
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MORELAND MEMORIAL PARK
20c. LOCATION — City or Town, State: PARKVILLE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry L. Fair
22. NAME AND ADDRESS OF FACILITY: EVANS FUNERAL CHAPEL 8800 HARFORD RD. PARKVILLE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Upper gastrointestinal bleeding

DUE TO (OR AS A CONSEQUENCE OF): b. Hypotension due to large aortic aneurysm.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c. Large multicystic spleen

DUE TO (OR AS A CONSEQUENCE OF): d. ____

Approximate Interval Between Onset and Death: 18 hours

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.
29c. LICENSE NUMBER: D-10940
29d. DATE SIGNED (Month, Day, Year): ▶ 4/12/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): APR 20 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall

DHMH-16 Rev 1/89

5

89 10281

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 10982
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUBY [redacted] HARRIS — RUBY HARRIS
2. DATE OF DEATH: MONTH 4/16 DAY YEAR 1989
3. TIME OF DEATH: 1:32 A.M.
4. SOCIAL SECURITY NUMBER: 212-26-3315
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 66 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 9/23/22
8. BIRTHPLACE (State or Foreign Country): N. CAROLINA
9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTO
9c. COUNTY OF DEATH: BALTO CITY

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: —
10c. CITY, TOWN OR LOCATION: 345 S. CHESTER ST
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 345 S Chester St
10f. ZIP CODE: 21231
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: W
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 GRADE — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SEAMSTRESS
16b. KIND OF BUSINESS/INDUSTRY: CLOTHING
17. FATHER'S NAME (First, Middle, Last): GROVER C BUCHANAN
18. MOTHER'S NAME (First, Middle, Maiden Surname): BESSIE HILL
19a. INFORMANT'S NAME (Type/Print): THOMAS BUCHANAN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 214 S. JULIA ST. ST.MARY GA 31558
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CRESTLAWN CEM
20c. LOCATION — City or Town, State: SYKESVILLE MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edward J. Weber
22. NAME AND ADDRESS OF FACILITY: JOHN H. WEBER & SONS INC 401 S. CHESTER ST

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | HYPOVOLAMIC SHOCK<br>Hypovolaemic shock. | |
| DUE TO (OR AS A CONSEQUENCE OF): | INTESTINAL OBSTRUCTION<br>Intestinal obstruction. | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | adhesions · ADHESIONS | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Acute renal failure.
GI bleeding.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): NO INJURY
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — (At home, farm, street, factory, office building, etc. (Specify))
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: GEORGE R. THOMAS, MD.
29c. LICENSE NUMBER: D18977
29d. DATE SIGNED (Month, Day, Year): ▶ 4/16/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 23 (Type/Print): GEORGE R. THOMAS MD. CHURCH HOSPITAL — GEORGE R. THOMAS / CHURCH ROAD OLP / 100 N BROADWAY BALTO, MD 21231
31. DATE FILED (Month, Day, Year): APR 24 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Landers

DHMH-18 Rev 1/89

89 10982

89 10983

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BARRY J. HAYES | | 2. DATE OF DEATH (Month, Day, Year): APRIL 18, 1989 | 3. TIME OF DEATH: 7:35 P M |
| 4. SOCIAL SECURITY NUMBER: 215-64-4869 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 34 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7-31-54 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: BALTIMORE City | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Talbot | 10c. CITY, TOWN OR LOCATION: Easton | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 130 Park Street | 10f. ZIP CODE: 21601 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager | 16b. KIND OF BUSINESS/INDUSTRY: Restaurant | |
| 17. FATHER'S NAME (First, Middle, Last): Irvin Hayes | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen M. Snyder | | |
| 19a. INFORMANT'S NAME (Type/Print): Helen M. Hayes | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 104 Tilghman Ave. Centreville, Md. 21617 | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Westview Crematory | 20c. LOCATION — City or Town, State: Catonsville, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Chiros | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Spontaneous Bacterial Peritonitis | 24 hrs. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Hepatocellular Carcinoma | 1 month |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Cirrhosis | 8 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Gastric and esophageal varices

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Caroline C. Philpott Resident | | ▶ 4/18/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Caroline C. Philpott, MD 600 N. Wolfe St. Baltimore, MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 10984
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| Hattie Haynes | | 4 29 89 | 7:32 PM |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| | 1 ☐ M 2 ☒ F | 77 YRS. | | | 8-20-11 | S. CAROLINA |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Liberty Medical Center | Baltimore, M.D. | BALTIMORE CITY |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | BALTIMORE CITY | BALTIMORE CITY | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 230 NORTH BEALE COURT | 21231 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | RETIRED | DOMESTIC |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| DAVE BRAND | CLARA ? |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| WARREN BRAND | 3 SOUTH PAYSON STREET (21223) |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | MT. ZION CEMETERY | BALTIMORE, MARYLAND |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Lynette K. Jones | BROWN-THOMPSON F.H. P.O. BOX 4433 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardia arrest 2° Arrythmia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CAD | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Seizure disorder | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] M.D. | 027718 | ▶ 7/29/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 4 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

2

89 1088P

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 10985
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Clifton | | Hazelton | April 24, 1989 | 7:30A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-14-4222 | 1 [X] M 2 [ ] F | 66 YRS. | | | 2/03/23 | MD |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| ~~Maryland~~ Maryland General Hospital | Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | | BALTIMORE | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 3100 HARFORD ROAD | 21218 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO — WWII | 1 [ ] YES 2 [X] NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| UNKNOWN | | DISABLED | VETERAN |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| CHARLESTON HAZELTON | BIRDIE WILLIAMS |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MARY WHITEHEAD | 3100 HARFORD ROAD BALTIMORE, MD 21218 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | GARRISON FOREST VET CEM | OWINGS MILLS, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ John B. Johnson Jr. | WM. C. MARCH F/H 1101 E. NORTH AVENUE |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Bronchopneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? | 26d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | | 1 [ ] YES 2 [ ] NO | |

| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Patrick Chau MD | N/A | ▶ 4/24/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Patrick Chau, M.D. c/o Maryland General Hospital

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 28 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 10985

89 10986

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): GARABED W HEGHINIAN
2. DATE OF DEATH: Month: April Day: 14 Year: 89
3. TIME OF DEATH: 2229 P M
4. SOCIAL SECURITY NUMBER: 212 10 4248
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 81 YRS. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
7. DATE OF BIRTH (Month, Day, Year): April 18, 1907
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 5528 Rusk Ave.
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 5+
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher
16b. KIND OF BUSINESS/INDUSTRY: High School
17. FATHER'S NAME (First, Middle, Last): Garabed Highinian
18. MOTHER'S NAME (First, Middle, Maiden Surname): Janet Eisenbrandt
19a. INFORMANT'S NAME (Type/Print): Mrs. Dorothy Bell
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 706 N. Howard St. Baltimore, Md. 21201
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Park Cemetery
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Herman Kamm
22. NAME AND ADDRESS OF FACILITY: MITCHELL-WIEDEFELD HOME, INC. 6500 York Road Baltimore, Md. 21212

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Respiratory Arrest | 3 mins |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Mesothelioma | 18 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Congestive Heart Failure

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph W Bell MD
29c. LICENSE NUMBER: D22334
29d. DATE SIGNED (Month, Day, Year): ▶ 14 April 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSW BEASLEY MD 7801 YORK Rd TOWSON md 21204
31. DATE FILED (Month, Day, Year): APR 24 1989
32. REGISTRAR'S SIGNATURE: Lisa Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-10987

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ~~Glenn~~ Glen C. Helsel ~~-Helsfel-~~ | | 2. DATE OF DEATH Month / Day / Year: 4-18-89 | 3. TIME OF DEATH: 9:05AM M |
| 4. SOCIAL SECURITY NUMBER: 202 48 4232 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 31 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): July 17, 1957 — 8. BIRTHPLACE (State or Foreign Country): Johnstown, PA |
| 9a. FACILITY NAME (If not institution, give street and number): University Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: n/a | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Pennsylvania | 10b. COUNTY: York | 10c. CITY, TOWN OR LOCATION: Stewartstown | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: R. D. 1 (3 Barton Circle) | 10f. ZIP CODE: 17361 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electrician | 16b. KIND OF BUSINESS/INDUSTRY: Benfield Co. |
| 17. FATHER'S NAME (First, Middle, Last): Conrad Helsel | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Julia Koba | |
| 19a. INFORMANT'S NAME (Type/Print): Kathleen Helsel (wife) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Grandview Cemetery | 20c. LOCATION — City or Town, State: Southmont, PA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: David B. Sauers | | 22. NAME AND ADDRESS OF FACILITY: Capitol Funeral Service, Falls Church, VA | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple injuries | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? XX [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX [X] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XX [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 XX [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 XX [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 4-18-89 | 28b. TIME OF INJURY: 6:00AM M | 28c. INJURY AT WORK? 1 [ ] YES 2 XX [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED: Passenger in pick-up/tractor trailer collision |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): road | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): I-83/Swann Road, Baltimore Co. |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. M.E. | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 4-19-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr., M.D. | 111 Penn Street, Baltimore, MD 21201 VC | |
| 31. DATE FILED (Month, Day, Year): APR 24 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

20

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 10988

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CHARLES VINCENT HENRY | | | 2. DATE OF DEATH (Month, Day, Year): 4-15-89 | 3. TIME OF DEATH: 2325 hrs M |
| 4. SOCIAL SECURITY NUMBER: 215-18-7442 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): May 26, 1921 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Church Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore City | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 5720 The Alameda Apt. D | | 10f. ZIP CODE: 21239 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: XX | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 4 Years | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Property Assessor | | 16b. KIND OF BUSINESS/INDUSTRY: State of Maryland |
| 17. FATHER'S NAME (First, Middle, Last): James D. Henry | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Sands | | |
| 19a. INFORMANT'S NAME (Type/Print): Mary Ann Henry | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2507 N. Charles St. Baltimore, Md. 21218 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Mary's Cemetery | | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F. Bannicke, Jr. | | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Md. 21212 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARCINOMA OF LUNG, METASTATIC — YEARS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. CARCINOMA OF LUNG, METASTATIC

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARCINOMA OF LARYNX
CARCINOMA OF LU LARYNX

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: JORGE SECADA LOVIO MD — Jorge C. Secada-Lovio, MD AD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-15-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JORGE C. SECADA-LOVIO, MD. CHURCH HOSPITAL, BALTIMORE, MD. 21231

31. DATE FILED (Month, Day, Year): APR 24 1989 | 32. REGISTRAR'S SIGNATURE:

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 10989 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FRANCIS O. Henson SR.
2. DATE OF DEATH (Month, Day, Year): 4-14-89
3. TIME OF DEATH: 2:45 A
4. SOCIAL SECURITY NUMBER: 216-30-6690
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 53 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1-07-36
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): MFL-5200 Eastern Ave
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md.
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Baltimore City
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2926 ELLICOTT DRIVE
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY? U.S.A
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Blk
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FOREMAN
16b. KIND OF BUSINESS/INDUSTRY: Bethlehem Steel
17. FATHER'S NAME (First, Middle, Last): JOHN T. HENSON
18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine THOMAS
19a. INFORMANT'S NAME (Type/Print): MR. TONY CHAMBERS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3321 LYNNE HAVEN DRIVE 21207
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): NEW CATHEDRAL CEM
20c. LOCATION — City or Town, State: BALTIMORE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Herbert E. Nutter
22. NAME AND ADDRESS OF FACILITY: NUTTER FUNERAL HOMES INC 2501 GWYNNS FALLS PARKWAY BALTIMORE, MARYLAND 21216

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia - Psuedomonas.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Recurrent Cancer of Head & Neck.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cachexia + Anemia 2nd to Ca
Multiple Pressure Sores

24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D24334
29d. DATE SIGNED (Month, Day, Year): ▶ 4/14/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Lindsay Pk - 5200 Eastern Ave - MFL/FSK - Balt, Md

31. DATE FILED (Month, Day, Year): APR 21 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Pinder

DHMH-16 Rev 1/89

83 10383

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 10990
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Ronald W. Hollenburry | | | 2. DATE OF DEATH (Month, Day, Year): 4-25-89 | 3. TIME OF DEATH: 9:25PM M |
| 4. SOCIAL SECURITY NUMBER: 216-48-7996 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 41 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9/1/47 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: A.A. | 10c. CITY, TOWN OR LOCATION: Glen Burnie | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 442 Willowdale Street | | 10f. ZIP CODE: 21061 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: Vietnam | 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+): | | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dispatcher | | 16b. KIND OF BUSINESS/INDUSTRY: Trucking |
| 17. FATNER'S NAME (First, Middle, Last): George Kenneth Hollenberry | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Regina Golden | | |
| 19a. INFORMANT'S NAME (Type/Print): Nancy Klasmeier | | 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1500 Charles Avenue Glen Burnie, Md. 21061 | | |
| 20a. METHOO OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crownsville Veterans Cemetery | | 20c. LOCATION — City or Town, State: Crownsville, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Thrombotic occlusion of right coronary artery | |
| DUE TO (OR AS A CONSEQUENCE OF): | Arteriosclerotic cardiovascular disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pancreatic pseudocyst

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| [X] YES 2 [ ] NO | [X] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF OEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| MD | OCME | ▶ 4-26-89 |

30. NAME AND ADDRESS OF PERSON WNO COMPLETEO CAUSE OF DEATN (ITEM 27) (Type, Print): Charles P. Kokes,M.D. 111 Penn Street,Baltimore,MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 28 1989 | Julia Davidson-Randall |

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 10991

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GEORGE O. HOPKINS | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 20 1989 | 3. TIME OF DEATH: 11 40 PM |
| 4. SOCIAL SECURITY NUMBER: 220-24-8944 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): July 21, 1928 | 8. BIRTHPLACE (State or Foreign Country): West Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Loch Raven V.A. Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Dundalk | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 7636 New Battle Grove Road | | 10f. ZIP CODE: 21222 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Korea | 13. WAS DECENDENT OF NISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 6+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction | 16b. KIND OF BUSINESS/INDUSTRY: Union | | |
| 17. FATHER'S NAME (First, Middle, Last): Clifford C. Hopkins | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Stella Hammons | | |
| 19a. INFORMANT'S NAME (Type/Print): Doris Hopkins | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7636 New Battle Grove Road, Baltimore, MD 21222 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery 4/24/89 | 20c. LOCATION — City or Town, State: Baltimore, Maryland | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Chas W. Fish | | 22. NAME AND ADDRESS OF FACILITY: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Baltimore, MD 21222 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | BILATERAL PNEUMONIA | 2 WKS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | RECURRENT ASPIRATIONS | 4 MOS. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | ADENOCARCINOMA OF GASTROESOPHAGEAL JUNCTION | 6 MOS. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC RENAL FAILURE. RESPIRATORY FAILURE - VENTILATION DEPENDENT

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 6 [ ] Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | M | | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| James A. Duke, MD | D36231 | ▶ 4/20/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JAMES A DUKE 21 S. EUTAW ST. BALTO MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 25 1989 | Julie Gardner-Landolfi |

DHMH-16 Rev 1/89

Items 23a thu28f per M.E. FilMG651 5/12/89 CG
Items:4,28a per ME G-656
10-18-89 cm

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 10992

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be detached by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | Jack | Clyde C. | Houghtling Jr. ~~Houghtling~~ | |
| 2. DATE OF DEATH (Month, Day, Year) | 4-12-89 | | | |
| 3. TIME OF DEATH | 11:14PM M | | | |
| 4. SOCIAL SECURITY NUMBER | 219-62-0057 | | | |
| 5. SEX | 1 [X] M 2 [ ] F | | | |
| 6. AGE (In yrs. last birthday) | 35 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7. DATE OF BIRTH (Month, Day, Year) | 12/19/1953 | | | |
| 8. BIRTHPLACE (State or Foreign Country) | Md. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) | Harbor Hospital Center | | | |
| 9b. CITY, TOWN OR LOCATION OF DEATH | Baltimore City | | | |
| 9c. COUNTY OF DEATH | - - | | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
| Maryland | --- | Baltimore | 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER | 2606 Marbourne Avenue, | 10f. ZIP CODE | 21230 |
| 10g. CITIZEN OF WHAT COUNTRY? | USA | | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
| Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | Welder | Self-employed |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
| Jack Clyde Houghtling, Sr. | Frances Eleanor Seifert Houghtling |
| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| Mrs. Frances E. Houghtling | 2714 Northshire Drive, Baltimore, Maryland 21230 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
| [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Cedar Hill Cemetery | Baltimore, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | Kevin E. Ecker | 22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Brooklyn, 237 E. Patapsco Ave., Balto., Md. 21225 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute narcotic intoxication | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) UNKNOWN | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: Unknown |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Unknown | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Unknown |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
| Mario F. Golle, Jr. MD | OCME | 4-12-89 |

| | |
|---|---|
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | |
| Mario F. Golle, Jr. MD | 111 Penn Street, Baltimore, MD 21201 VC |
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
| APR 20 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 10993
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Gilbert | W. | Hovermale | 4 / 12 / 89 | 9:25 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-20-5490 | 1 [X] M 2 [ ] F | 59 [redacted] YRS. | | | Sept. 29, 1929 | W. Va. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| JOHNS HOPKINS HOSPITAL 600 N WOLFE ST. | BALTIMORE CITY | BALTIMORE CITY |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Penna. | Franklin | St. Thomas Twp. | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 7484 Valley Camp Rd. St. Thomas, Pa. | 17252 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Korean Conflict | 1 [ ] YES 2 [X] NO. Specify: | Specify: Caucasian |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | 4+ | Attorney | Law |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Glen Hovermale | Freda Coe |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sarah F. Hovermale | 7484 Valley Camp Rd., St. Thomas, Pa. 17252 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Corpus Christi Cem. | Chambersburg, Pa. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Robert A. Myers | 91 WILLIS ST. MYERS FUNERAL HOME WESTMINSTER, MD. |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Lung Ca. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | 3 mths |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) |
|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| P. Keiser MD | D36904 | ▶ 4/12/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Philip Keiser 600 N Wolfe St Balto MD 21205

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 22 1989 | Gisha Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 10994
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2-4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JAMES HUFF | | | | 2. DATE OF DEATH (Month, Day, Year): 4-21-89 | 3. TIME OF DEATH: 445 AM |
| 4. SOCIAL SECURITY NUMBER: 260-14-8645 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 71 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3-21-18 | 8. BIRTHPLACE (State or Foreign Country): GEORGIA |
| 9a. FACILITY NAME (If not institution, give street and number): MERCY HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY, MD | | 9c. COUNTY OF DEATH: | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: PUMPHREY | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO | |
| 10e. STREET AND NUMBER: 111 BISHOP AVENUE | | 10f. ZIP CODE: 21225 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: W.W. II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 8 +) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER | | 16b. KIND OF BUSINESS/INDUSTRY: CONSTRUCTION COMPANY | |
| 17. FATHER'S NAME (First, Middle, Last): EARL HUFF | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): BEATRICE STATION | | | |
| 19a. INFORMANT'S NAME (Type/Print): SUSAN HUFF | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 111 BISHOP AVENUE PUMPHREY MD 21225 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CROWNSVILLE VETERANS CEM. | | 20c. LOCATION — City or Town, State: CROWNSVILLE MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gloria Adams Jones | | 22. NAME AND ADDRESS OF FACILITY: MARSHALL W. JONES, JR. FUNERAL HOME 401 EDMONDSON AVE. 21229 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. PNEUMONIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CEREBRAL VASCULAR ACCIDENT | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DIABETES MELLITUS, HYPERTENSION | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M.D.

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year): ▶ 4/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TONY HSIAO M.D MERCY HOSPITAL BALT MD 21202

31. DATE FILED (Month, Day, Year): 4/21/ APR 24 1989

32. REGISTRAR'S SIGNATURE: Julia Davison D. Asst

DHMH-18 Rev 1/89

89 1099F

89 10995

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HELEN JULIA HAMBRUCH | | | 2. DATE OF DEATH (Month, Day, Year): 4 / 23 / 89 | 3. TIME OF DEATH: 12:10 PM |
| 4. SOCIAL SECURITY NUMBER: 215-09-8202 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2/14/16 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 139 Siegwart Lane | | 10f. ZIP CODE: 21229 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Wireman | | 16b. KIND OF BUSINESS/INDUSTRY: Westinghouse |
| 17. FATHER'S NAME (First, Middle, Last): John H. Murk | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): susanna Habighurst | | |
| 19a. INFORMANT'S NAME (Type/Print): Joan S. Magaha | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3004 Elizabeth Avenue Baltimore, Md. 21229 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery | | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE RESPIRATORY FAILURE

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. C.O.P.D.

DUE TO (OR AS A CONSEQUENCE OF):

c. Chronic Bronchitis

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Dr Rafael Lao | Resident | ▶ 4/03/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr R Lao St Agnes Hospital Baltimore Md 21229

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 24 1989 | Julia Davidson-Landers |

DHMH-16 Rev 1/89

89 10332

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 10996
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Elwood William Hicks, Sr. | | 2. DATE OF DEATH (Month, Day, Year): April 16 1989 | 3. TIME OF DEATH: 19:45 M |
| 4. SOCIAL SECURITY NUMBER: 232.01.8921 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): May 10, 1919 |
| 8. BIRTHPLACE (State or Foreign Country): West Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: Baltimore City | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 106 Point Pleasant Road | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5+): None | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineer Railroad | 16b. KIND OF BUSINESS/INDUSTRY: B & O Railroad | |
| 17. FATHER'S NAME (First, Middle, Last): Elmer Hicks | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Fannie Seldon | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Julia Hicks | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 106 Point Pleasant Road, Glen Burnie, Md. 21061 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park | 20c. LOCATION — City or Town, State: Elkridge, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jamie Seibert | 22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md.21061 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Lung CA.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Hemorrhage Rt chest wall 2° to metastatic CA.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) St Agnes |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Peter R. Ledoux M.D. | | ▶ 4/16/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Peter R. Ledoux, M.D.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 18 1989 | Julia Davidson-Landers |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 10997

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 must be completed by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, ... attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified before cremation.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): C. READ HODDINOTT | | | | 2. DATE OF DEATH (Month, Day, Year): 4 25 89 | 3. TIME OF DEATH: 1 30 PM |
| 4. SOCIAL SECURITY NUMBER: 212-20-0241 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 62 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): June 22,1926 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): University Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: City |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Carroll | 10c. CITY, TOWN OR LOCATION: Westminster | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 103 E. Green Street | 10f. ZIP CODE: 21157 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 XX Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WWll | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 Years | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Broker | 16b. KIND OF BUSINESS/INDUSTRY: Real Estate |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Fogler Hoddinott | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Cecelia Read |
| 19a. INFORMANT'S NAME (Type/Print): Cindy Hoddinott-Alonso | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 64 Anna Court, Gaithersburg, Maryland 20877 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Crematory 4-27-89 | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wallace S. Brooks, Jr. | 22. NAME AND ADDRESS OF FACILITY: 1050 York Rd. 21204 Ruck Towson Funeral Home, Inc. Towson, Md. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Probable Completion of Dissection @ Aortic Root | 30 mins |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Dissecting Thoracic Aorta | 5, 5 hrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Atherosclerosis of Great Vessels | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): N/A | 28b. TIME OF INJURY: N/A | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO: N/A |
| | 28d. DESCRIBE HOW INJURY OCCURED: N/A | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A | |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Elaine James MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/25/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Elaine James MD 22 South Greene St Balt MD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): 4/25/89 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 10998

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): John HENRY Harris | | | | 2. DATE OF DEATH (Month / Day / Year): 04 - 16 - 89 | 3. TIME OF DEATH: 6:00 AM |
| 4. SOCIAL SECURITY NUMBER: 214-30-1123 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 56 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 06-05-32 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Deaton Hosp & Medical Ctr | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: — |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Prince George | 10c. CITY, TOWN OR LOCATION: Beltsville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 4005 Foreston Road | 10f. ZIP CODE: 20705 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: 1953- 1955 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 years; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Surveyor | 16b. KIND OF BUSINESS/INDUSTRY: Private Firm | |
| 17. FATHER'S NAME (First, Middle, Last): XXXXXXXXXX Thomas Edward XXXXXXX Harris | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elsie King | |
| 19a. INFORMANT'S NAME (Type/Print): Lois Ellen Harris (wife) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as # 10 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Cemetery | 20c. LOCATION — City or Town, State: Elkridge Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald V. Borgwardt | 22. NAME AND ADDRESS OF FACILITY: Borgwardt Funeral Home, 4400 Powder Mill Road, Beltsville, Md. 20705 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cerebro Vascular Accident, Coma | 6 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Hypertensive Arteriosclerotic Cardio Vascular Disease | years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Coronary Artery Disease | years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hangnail, right big toe, Decubitus Ulcer

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Rolando V. Goco MD | 29c. LICENSE NUMBER: DO 1860 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/16/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Rolando V. Goco, MD, Deaton Hospital & Medical Center

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 18 1989 | 32. REGISTRAR'S SIGNATURE: Barbara Lindsay |

DHMH-16 Rev 1/89

S 236 64 08 A
HEADLEY, CHARLES
4/23/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 10999

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MD 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be ... hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 ... for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): CHARLES HEADLEY

**2. DATE OF DEATH** (Month, Day, Year): APRIL 23, 1989

**3. TIME OF DEATH**: 2:45 P M

**4. SOCIAL SECURITY NUMBER**: 288-28-4668

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 55 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 2-17-1934

**8. BIRTHPLACE** (State or Foreign Country): Ohio

**9a. FACILITY NAME** (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTIMORE CITY

**9c. COUNTY OF DEATH**: BALTIMORE

**RESIDENCE OF DECEDENT**

**10a. STATE**: Ohio

**10b. COUNTY**: Muskingum

**10c. CITY, TOWN OR LOCATION**: Blue Rock

**10d. INSIDE CITY LIMITS?** 1 [ ] YES 2 [X] NO

**10e. STREET AND NUMBER**: 10595 Center Road

**10f. ZIP CODE**: 43720

**10g. CITIZEN OF WHAT COUNTRY?**: U. S. A.

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Maintenance Worker

**16b. KIND OF BUSINESS/INDUSTRY**: Boiler&Raditor Manufacture

**17. FATHER'S NAME** (First, Middle, Last): Walter Headley

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Myrtle Swingle

**19a. INFORMANT'S NAME** (Type/Print): Norma Headely

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10595 Center Road Blue Rock, Ohio 43720

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Rose Hill Cemetery

**20c. LOCATION — City or Town, State**: Muskingum, Ohio

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Michael P. Marzullo

**22. NAME AND ADDRESS OF FACILITY**: Marzullo Funeral Service
3981 Carrollton Road Upperco, MD. 21155

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | INTRACRANIAL HEMMORAGE | 24 HOURS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | BONE MARROW TRANSPLANT | 1 MO. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | CHRONIC MYELOGENOUS LEUKEMIA | 4 yrs. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [X] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [X] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [X] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: REIMER

**29c. LICENSE NUMBER**:

**29d. DATE SIGNED** (Month, Day, Year): ▶ 4/23/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): ROBERT H. REIMER, MD JOHNS HOPKINS HOSPITAL, BALTIMORE MARYLAND

**31. DATE FILED** (Month, Day, Year): 4/25/1989

**32. REGISTRAR'S SIGNATURE**: Nina Brandon-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11000

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Blanche Hall
2. DATE OF DEATH (Month, Day, Year): 4 9 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 229-32-2189
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7/10/16
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3438 Ravenwood Ave.
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): unknown — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): telephone operator
16b. KIND OF BUSINESS/INDUSTRY: United Telephone
17. FATHER'S NAME (First, Middle, Last): Claude Testerman
18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Wright
19a. INFORMANT'S NAME (Type/Print): Fred Testerman
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3438 Ravenwood Ave/Balto. MD 21213
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn
20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: John A. Moran Funeral Home, 3000 E. Baltimore St. 21224

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Metastatic Rectal Carcinoma | 1 year |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Howard C. Berg MD
29c. LICENSE NUMBER: D34821
29d. DATE SIGNED (Month, Day, Year) ▶ 4/10/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Howard C. Berg, M.D. 711 W. 40th St Balto, Md 21211
31. DATE FILED (Month, Day, Year): APR 11 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 11001

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Baby Boy HALL (BABY BOY HALL)

**2. DATE OF DEATH** (Month, Day, Year): 03 / 16 / 1989

**3. TIME OF DEATH**: 1830 ☒ P M

**4. SOCIAL SECURITY NUMBER**: N/A

**5. SEX**: 1 ☒ M 2 ☐ F

**6. AGE** (In yrs. last birthday): 0 YRS. — IF UNDER 1 YEAR: MONTHS 0, DAYS 0 — IF UNDER 24 HRS.: HOURS 1, MIN. 10

**7. DATE OF BIRTH** (Month, Day, Year): 3/16/89 (03/16/89)

**8. BIRTHPLACE** (State or Foreign Country): MD

**9a. FACILITY NAME** (If not institution, give street and number): ST. AGNES HOSPITAL

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTIMORE

**9c. COUNTY OF DEATH**: --

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md.

**10b. COUNTY**: —

**10c. CITY, TOWN OR LOCATION**: Balto.

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 2701 Chelsea Terrace

**10f. ZIP CODE**: 21216

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: BLACK

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): N/A
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): N/A

**16b. KIND OF BUSINESS/INDUSTRY**: N/A

**17. FATHER'S NAME** (First, Middle, Last):

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): COURTNEY RENEE HALL

**19a. INFORMANT'S NAME** (Type/Print): COURTNEY RENEE HALL

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2701 CHELSEA TERRACE, BALTIMORE, MARYLAND 21216

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): NEW CATHEDRAL CEMETEYR

**20c. LOCATION — City or Town, State**: BALTIMORE, MARYLAND

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Russell Witzke

**22. NAME AND ADDRESS OF FACILITY**: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES
1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Severe prematurity
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☐ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year): N/A

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**: N/A

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify): N/A

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State): N/A

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Hong Yu Chen, M.D.

**29c. LICENSE NUMBER**:

**29d. DATE SIGNED** (Month, Day, Year): ▶ 3/16/1989

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Hong Yu CHEN. St. Agnes Hospital, 900 Caton Ave. Balto MD 21229

**31. DATE FILED** (Month, Day, Year): APR 24 1989

**32. REGISTRAR'S SIGNATURE**: Judith Snider-Andrews

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11002
REG. NO.

5

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NELSON C HETRICK
2. DATE OF DEATH: MONTH 4 DAY 30 YEAR 89
3. TIME OF DEATH: 8 44 PM
4. SOCIAL SECURITY NUMBER: 214 26 9179
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 58 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 1 5 31
8. BIRTHPLACE (State or Foreign Country): BALT, MD
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hosp
9b. CITY, TOWN OR LOCATION OF DEATH: BALT MD
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3318 Elm Ave
10f. ZIP CODE: 21211
10g. CITIZEN OF WHAT COUNTRY? US
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1951-53
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Wh
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plasterer
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Herbert Hetrick
18. MOTHER'S NAME (First, Middle, Maiden Surname): Agnes Miller
19a. INFORMANT'S NAME (Type/Print): Edith Lockner
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3318 Elm Avenue, Baltimore, Md, 21211
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lakeview Memorial Park
20c. LOCATION — City or Town, State: Sykesville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ A. Alan Seitz Jr
22. NAME AND ADDRESS OF FACILITY: A. Alan Seitz, Jr. Funeral Home, 3818 Roland Avenue, Balto., Md. 21211

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Abdominal Aneurysm - rupture | 8 hr |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Richard J Dimmick
29c. LICENSE NUMBER: D23076
29d. DATE SIGNED (Month, Day, Year): ▶ 4-30-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RICHARD L DIMMICK 3730 FALLS RD BALT MD
31. DATE FILED (Month, Day, Year): MAY 2 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11003

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lue Hall | | | 2. DATE OF DEATH (Month, Day, Year): April 12, 1989 | 3. TIME OF DEATH: 2:15P M |
| 4. SOCIAL SECURITY NUMBER: 241-10-4197A1 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2/17/1900 | 8. BIRTHPLACE (State or Foreign Country): N. CAROLINA |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2241 BRUNT STREET | | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): PETE WARD | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): PATIENCE RUFFIN | |
| 19a. INFORMANT'S NAME (Type/Print): MAZIE WARD | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 518 GOLD STREET: BALTO., MD. 21217 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTERN STAR CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy O. Dyett | | 22. NAME AND ADDRESS OF FACILITY: LEROY O. DYETT & SON F.H., INC. 4600 LIBERTY HEIGHTS AVENUE 21207 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arrhythmias | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Pneumonia; Chronic renal failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: ☒ 1 Natural; 2 ☐ Accident; 3 ☐ Suicide; 4 ☐ Homicide; 5 ☐ Pending investigation; 6 ☐ Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: IAN TANG. M.D | 29c. LICENSE NUMBER: n/a | 29d. DATE SIGNED (Month, Day, Year): 4/12/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ian Tang, M.D. c/o Maryland General Hospital

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 14 1989 | 32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall |

DHMH-16 Rev 1/89

22

89 11004

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): VERNON CONRAD HANEY | | | | 2. DATE OF DEATH (Month, Day, Year): 4 / 5 / 89 | 3. TIME OF DEATH: 0700 M |
| 4. SOCIAL SECURITY NUMBER: 213-28-3530 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 83 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 7/20/05 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1207 Carroll Street | 10f. ZIP CODE: 21230 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Civil Engineer | 16b. KIND OF BUSINESS/INDUSTRY: Naval Academy | |
| 17. FATHER'S NAME (First, Middle, Last): George T. Haney | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Abblie Eichhorn | | |
| 19a. INFORMANT'S NAME (Type/Print): Ethel Price | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1207 Carroll Street Baltimore, Md. 21230 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jackie D. Shannon | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. acute anterior MI. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Heart Block. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. arrhythmias (VTach - Vfib) | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Anand P. DiNella | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SAH 900 Caton ave baltimore.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 7 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 11005

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RACHEL (RAYE) F. HARMATZ | | | 2. DATE OF DEATH: MONTH 4 DAY 3 YEAR 89 | 3. TIME OF DEATH: 12 midnight |
| 4. SOCIAL SECURITY NUMBER: 217-05-4257 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 06/05/10 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND Baltimore |
| 9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL of Baltimore | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, MD. | 9c. COUNTY OF DEATH | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: M.D. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE. | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3903 CLARINTH RD | 10f. ZIP CODE: 21215 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES XX | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: AT HOME | |
| 17. FATHER'S NAME (First, Middle, Last): OSCAR FELDSTEIN | 18. MOTHER'S NAME (First, Middle, Maiden Surname): EMMA GERSON | | |
| 19a. INFORMANT'S NAME (Type/Print): LEONARD HARMATZ | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3903 CLARINTH RD 21215 Baltimore, MD. | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SHAAREI ZION - ROSEDALE, MARYLAND | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jay Levin | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Arrest 2° Lymphoma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Δ NS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mansourian MD. H.O. | 29c. LICENSE NUMBER: 9455 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/3/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MANSOURIAN M.D. SINAI Hospital of Baltimore, Baltimore, MD. | | |
| 31. DATE FILED (Month, Day, Year): 4/3/89 APR 07 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 11006

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BERNARD T. HAWKINS
2. DATE OF DEATH: MONTH 4 DAY 20 YEAR 89
3. TIME OF DEATH: 1:05 AM
4. SOCIAL SECURITY NUMBER: 219 30 7357
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 55 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 02/28/34
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): Univ of Maryland Hosp
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: —

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1036 Valley St
10f. ZIP CODE: 21202
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 7th GRADE — College (1-4 or 5+):
15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): WAREHOUSE MAN
16b. KIND OF BUSINESS/INDUSTRY: G.S.A. FED. GOVERNMENT
17. FATHER'S NAME (First, Middle, Last): BERNARD HAWKINS
18. MOTHER'S NAME (First, Middle, Maiden Surname): BESSIE SIMMS
19a. INFORMANT'S NAME (Type/Print): MRS. OSABELL HAWKINS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2310 LAURETTA AVENUE, BALTIMORE, MD. 21223
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK
20c. LOCATION — City or Town, State: BALTIMORE, CO., MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vernon R. Bailey
22. NAME AND ADDRESS OF FACILITY: NUTTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Multiple Organ Failure | 1 week |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Aortic Thrombosis | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | atherosclerotic disease | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Electrolyte abnormalities

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): NA
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): NA
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: John a Steward
29c. LICENSE NUMBER: House Officer
29d. DATE SIGNED (Month, Day, Year) ▶ 4/20/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John a Steward Univ MD Hosp.
31. DATE FILED (Month, Day, Year): 4/20/89
32. REGISTRAR'S SIGNATURE: APR 21 1989 Julia Davidson-Randall

OHMH-16 Rev 1/89

89 11006

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11007
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Shirley Herman | | | | 2. DATE OF DEATH (Month, Day, Year): April 01, 1989 | 3. TIME OF DEATH: 1:00 p M |
| 4. SOCIAL SECURITY NUMBER: 214-40-1625 | 5. SEX: 1 ☐ M 2 ☒ F XX | 6. AGE (In yrs. last birthday): 89 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): DEC. 25, 1899 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO X |
| 10e. STREET AND NUMBER: 2525 EUTAW PLACE, Apt 2H | | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed XX 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO XX IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO X Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): REGISTERED NURSE | 16b. KIND OF BUSINESS/INDUSTRY: SINAI HOSPITAL | |
| 17. FATHER'S NAME (First, Middle, Last): SAMUEL GANDERSON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CELIA GENDASON | |
| 19a. INFORMANT'S NAME (Type/Print): LEON GANDERSON | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 445 HARITON CT. NORFOLK, VA 23505 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial XX 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BETH HAMEDROSH HAGODOL | 20c. LOCATION — City or Town, State: ROSEDALE, BALTO., MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellensue Levinson | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD BALTO., MD 21215 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Possible Cerebrovascular accident
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Metabolic acidosis
DUE TO (OR AS A CONSEQUENCE OF):
c. Possible sepsis- unknown origin
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: B. J. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Benjamin Stallings, M.D. c/o Maryland General Hospital

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 1007

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11008
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES A. HICKMAN
2. DATE OF DEATH: MONTH April DAY 10, YEAR 1989
3. TIME OF DEATH: 6:35 PM
4. SOCIAL SECURITY NUMBER: 218-42-0176
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 60 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): Aug. 15, 1928
8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): Bon Secours
9b. CITY, TOWN OR LOCATION OF DEATH: BALTimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1819 RIGGS AVENUE
10f. ZIP CODE: 21217
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BALTO. CITY
16b. KIND OF BUSINESS/INDUSTRY: RETIRED
17. FATHER'S NAME (First, Middle, Last): JOSEPH B. HICKMAN
18. MOTHER'S NAME (First, Middle, Maiden Surname): BLANCHE ANDERSON
19a. INFORMANT'S NAME (Type/Print): ANNA HICKMAN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1819 RIGGS AVENUE BALTO., MD 21217
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOUNT AUBURN CEMETERY
20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard Greene
22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or hesrt fellure. Llet only one ceuse on esch line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finsl disease or condition resulting in death) →
a. Sepsis 2° pneumonitis (Bilateral)
DUE TO (OR AS A CONSEQUENCE OF):
b. Brain Tumor (L)
Sequentisily liet conditions, if any, leading to immediete cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
c. Acute Cerebral infarction (L)
DUE TO (OR AS A CONSEQUENCE OF):
d. Diabetes Mellitus type II

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Acute upper GI Gastrointestinal bleeding 2° Gastritis + Hiatal Hernia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: BERNARDO D. Gonzales
29c. LICENSE NUMBER: D18714
29d. DATE SIGNED (Month, Day, Year): ▶ APRil 10 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BERNARDO D. GONZALES M.D. 2000 N. Baltimore St, md. 21223
31. DATE FILED (Month, Day, Year): APR 13 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson Rogers

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH-16 Rev 1/89

89 11009

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LOUIS JOHN HOEHL, SR.

2. DATE OF DEATH (Month, Day, Year): 4 4 89

3. TIME OF DEATH: 5 17 pm M

4. SOCIAL SECURITY NUMBER: 215-01-8476

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 83 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7. DATE OF BIRTH (Month, Day, Year): 5/1/05

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Lansdowne

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 24 Carling Circle

10f. ZIP CODE: 21227

10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Guard - Supervisor

16b. KIND OF BUSINESS/INDUSTRY: Cont. Can Co.

17. FATHER'S NAME (First, Middle, Last): Otto Hoehl

18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Hoffman

19a. INFORMANT'S NAME (Type/Print): C. Evelyn Hoehl

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 24 Carling Circle Baltimore, Md. 21227

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Redeemer Cemetery

20c. LOCATION — City or Town, State: Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Teresa Lafferty

22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio respiratory Arrest

DUE TO (OR AS A CONSEQUENCE OF): b. Probably 2° to acute MI

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c. 2° CRF and hyperkalemia

DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: S. S MD

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year): ▶ 4/4/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Samer. Sukki @ 300 Caton Ave BALT-MD 21229

31. DATE FILED (Month, Day, Year): APR 5 1989

32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall

DHMH-16 Rev 1/89

89 11010

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GLADYS MARY HARRIS
2. DATE OF DEATH: MONTH 4 DAY 14 YEAR 89
3. TIME OF DEATH: 11 [P] M
4. SOCIAL SECURITY NUMBER: 213-20-7971
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11/12/1918
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMOR
9c. COUNTY OF DEATH: MD

**RESIDENCE OF DECEDENT**

10a. STATE: MD
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3734 DOLFIELD AVENUE
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12TH — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BEAUTICIAN
16b. KIND OF BUSINESS/INDUSTRY: SELF-EMPLOYED
17. FATHER'S NAME (First, Middle, Last): ADRIAN HOLTON
18. MOTHER'S NAME (First, Middle, Maiden Surname): RUTH CURTIS
19a. INFORMANT'S NAME (Type/Print): HERMAN J. HARRIS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3734 DOLFIELD AVENUE 21215
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VET. CEM.
20c. LOCATION — City or Town, State: BALTIMORE, CO., MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ernest Terry-Nutter
22. NAME AND ADDRESS OF FACILITY: NUTTER FUNERAL HOMES, INC 2501 GWYNNS FALLS PARKWAY BALTIMORE, MARYLAND. 21216

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory erreat, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a. Respiratory and cardiac arrest
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Lung Ca, met to liver
DUE TO (OR AS A CONSEQUENCE OF):
c. metabolic acidosis Shock
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) — 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: R Atha 9412
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): ▶ 4/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R ATHA
31. DATE FILED (Month, Day, Year): 4/14/89 APR 21 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Pendleton

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11011

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HOGSTON, BETTY | | | 2. DATE OF DEATH (Month, Day, Year): April 6 1989 | 3. TIME OF DEATH: 1300 M |
| 4. SOCIAL SECURITY NUMBER: 225-30-7871 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 92 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 2-13-1897 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 407 Font Hill Avenue | | 10f. ZIP CODE: 21223 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Shirt folder | 16b. KIND OF BUSINESS/INDUSTRY: Stegars Laundry | |
| 17. FATHER'S NAME (First, Middle, Last): ~~MXXXXXXXXXXXXXX~~ Boasher Doane | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Chapman | |
| 19a. INFORMANT'S NAME (Type/Print): Margaret Tabor | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 506 Hurley Ave. Baltimore, MD 21223 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Good Shepherd Cemetery | 20c. LOCATION — City or Town, State: Ellicott City, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dawn C. Smith | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Epidural hematoma | 6 Days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. | Head trauma d° to fall | 6 Days |
| DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: congestive heart failure

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☒ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 3/29/89 | 28b. TIME OF INJURY: AK M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO | 28d. DESCRIBE HOW INJURY OCCURED: fell down stairs |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 407 Font Hill Ave, Balt. |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Frank Lin MD | 29c. LICENSE NUMBER: | 29d. DATE SIGNED (Month, Day, Year): 3/6/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANK LIN MD 900 CATON AVE. BALT MD 21229 | | |
| 31. DATE FILED (Month, Day, Year): APR 10 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

DHMH-16 Rev 1/89

89 11011

89 11012

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): ADA MARIE HOLLAND

**2. DATE OF DEATH** (Month, Day, Year): APRIL 3, 1989

**3. TIME OF DEATH**: M

**4. SOCIAL SECURITY NUMBER**: 217-40-7835

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 78 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): May 24, 1910

**8. BIRTHPLACE** (State or Foreign Country): Ohio

**9a. FACILITY NAME** (If not institution, give street and number): 6008 Clearspring Rd.

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 6008 Clearspring Rd.

**10f. ZIP CODE**: 21212

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 Years
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Seamstress-Fitter

**16b. KIND OF BUSINESS/INDUSTRY**: Dept. Store

**17. FATHER'S NAME** (First, Middle, Last): Floyd Wilson Sherman

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Iva M. Clement

**19a. INFORMANT'S NAME** (Type/Print): Evelyn M. Norris

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1, Box 335, Roseland, Va. 22967

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Saters Baptist Church Cem.

**20c. LOCATION — City or Town, State**: Brooklandville Maryland

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ James F. Bennett, Jr.

**22. NAME AND ADDRESS OF FACILITY**: Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Breast Cancer | 1½ yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Charles Padgett M.D.

**29c. LICENSE NUMBER**: D15546

**29d. DATE SIGNED** (Month, Day, Year): ▶ 4-3-89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Charles Padgett, M.D. 5601 Loch Raven Blvd. Baltimore, Md. 21239

**31. DATE FILED** (Month, Day, Year): APR 7 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11013
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-removal permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Katharine Bertha Hollenshade | | | | | 2. DATE OF DEATH (Month, Day, Year): April 17, 1989 | 3. TIME OF DEATH: 5:15A M |
| 4. SOCIAL SECURITY NUMBER: 218-18-9810 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 92 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Feb.5,1897 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2211 W. Rogers Ave. | | 10f. ZIP CODE: 21209 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): Karl Muly | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara Klotz | | |
| 19a. INFORMANT'S NAME (Type/Print): William Muly | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6825 Campfield Rd., Apt.8-G, Balto., Md. 21207 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Cemetery 4/20/89 | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | 22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cerebrovascular accident
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Accerated hypertension
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Previous Myocaridal infarction 1981
Previous cerebrovascular accidents 1987

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 25e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | | ▶ 4/17/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Eric Khairallah, M.D. c/o Maryland General Hospital

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 21 1989 | Julia Davidson-Landers |

DHMH-15 Rev 1/89

89 11013

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11014
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Rose ROSE Holmes HOLMES | | | | 2. DATE OF DEATH: MONTH 04 DAY 05 YEAR 89 | 3. TIME OF DEATH: 7 30 A M |
| 4. SOCIAL SECURITY NUMBER: 219-10-0317 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 92 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 07-04-1896 | 8. BIRTHPLACE (State or Foreign Country): MASS. |
| 9a. FACILITY NAME (If not institution, give street and number): Levindale Hebrew Geriatric Ctr | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 21 Terron Court | | 10f. ZIP CODE: 21234 | 10g. CITIZEN OF WHAT COUNTRY? US |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: AT HOME | |
| 17. FATHER'S NAME (First, Middle, Last): IRVING FREED | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY UNKNOWN | |
| 19a. INFORMANT'S NAME (Type/Print): HOWARD HOLMES | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21 TERRON CT. PARKVILLE, MD 21234 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MORELAND MEMORIAL PARK | 20c. LOCATION — City or Town, State: BALTIMORE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellsworth Levinson | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. PNEUMONIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. SENILE DEMENTIA OF ALZHEIMER'S TYPE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D2560 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-5-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SETH WAR, M.D., 2434 W. BELVERDERE AVE, BALTIMORE, MD 21215

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 07 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson Rankin |

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11015

571

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE W. HORSEY
2. DATE OF DEATH: MONTH 04 DAY 05 YEAR 1989
3. TIME OF DEATH: 6:45 A M
4. SOCIAL SECURITY NUMBER: 214 16 7783
5. SEX: 1 X M 2 ☐ F
6. AGE (In yrs. last birthday): 66 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 02-20-1923
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): HOLEWOOD HOSPITAL - SOUTH
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: Baltimore City

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: Baltimore City
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 845 W. 36TH STREET
10f. ZIP CODE: 21211
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: CAUCASIAN
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Roofer
16b. KIND OF BUSINESS/INDUSTRY: Roofing
17. FATHER'S NAME (First, Middle, Last): William Samuel Horsey
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary P. Dowing
19a. INFORMANT'S NAME (Type/Print): Helen Squiller
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 845 W. 36th Street, Baltimore, Maryland 21211
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Westview Memorial Park
20c. LOCATION — City or Town, State: Westview, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lynn Burgee Henss
22. NAME AND ADDRESS OF FACILITY: Burgee-Henss Funeral Home, 3631 Falls Road, Baltimore, Md. 21211

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ACUTE MYOCHOIN INFARCTION | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ASCVD | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D17092
29d. DATE SIGNED (Month, Day, Year): ▶ 4/5/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ANTHONY M. LOSHINSKI 3640 FORDS LANE BALTO MD 21215
31. DATE FILED (Month, Day, Year): APR 10 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

89 11015

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11016
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): NORMAN R. HARRIS | | | 2. DATE OF DEATH (Month, Day, Year): April 18, 1989 | 3. TIME OF DEATH: 4:43 A. M |
| 4. SOCIAL SECURITY NUMBER: 220-05-2453 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Sept 5, 1919 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2224 Louise Avenue | | 10f. ZIP CODE: 21214 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Navy WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 8+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintenance | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Samuel H. Harris | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie E. Yeager | |
| 19a. INFORMANT'S NAME (Type/Print): Dian E. Harris | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2224 Louise Avenue Baltimore, Md. 21214 | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Cem. 4/19/89 | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Milton J. Knight Jr. Milton J. Knight Jr. | 22. NAME AND ADDRESS OF FACILITY: 21214 Leonard J. Ruck, Inc. Baltimore, Md. 21214 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Myocardial infarction | 2 hours |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Coronary artery disease | 12 years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Carl Friedman MD M.D. | 29c. LICENSE NUMBER: D20688 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/18/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Carl S. Friedman M.D. 660 Kenilworth Dr., Towson, Md. | | | |
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall | | |

DHMN-16 Rev 1/89

89 11016

89 11017

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH Month / Day / Year | 3. TIME OF DEATH |
|---|---|---|---|---|
| PAMELA | RITA | HARRIS | 4 / 16 / 89 | 7:02 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-62-5083 | 1 ☐ M 2 ☒ F | 36 YRS. | | | 3 17 1953 | MARYLAND |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 1526 Chesapeake Ave. | Baltimore | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | | BALTIMORE 21226 | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 2101 HOLLINS STREET | 21223 | U. S. A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12TH GRADE | | LABORER | OPTIC GRAPHICS |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| EARL COATES | MABEL COATES |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MRS. MABEL COATES | 2101 HOLLINS STREET, BALTIMORE, MD. 21223 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | ARBUTUS MEMORIAL PARK | BALTIMORE CO., MD. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Gary L. Rollins | NUTTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such se cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute drug intoxication | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) scene |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☒ Could not be determined | 4-16-89 | M | 1 ☐ YES 2 ☒ NO | Unknown |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| house | 1526 Chesapeake Ave.,Balto. City, MD |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin M.D. | OCME | ▶ 4-16-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Julia C. Goodin, M.D. 111 Penn St., Balto., MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 21 1989 | Julia Davidson-Lindsay |

DHMH-16 Rev 1/89

89 11017

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11018

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WALTER HARRIS, JR
2. DATE OF DEATH (Month, Day, Year): 4 14 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 220-05-9361
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5 11 1919
8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): 3705 OVERVIEW ROAD
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3705 Overview Road
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? U S A
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Walter Harris, Sr
18. MOTHER'S NAME (First, Middle, Maiden Surname): Julia Gibson
19a. INFORMANT'S NAME (Type/Print): Florine Harris
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3705 Overview Road Baltimore, Md 21215
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Vet
20c. LOCATION — City or Town, State: Owings Mills, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Florine A. Thompson
22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 4300 WABASH AVENUE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic prostate cancer | 3 yrs. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Chang, MD
29c. LICENSE NUMBER: D16587
29d. DATE SIGNED (Month, Day, Year): ▶ 4/17/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 5601 Loch Raven Blvd, Suite 107, Baltimore, Md. 21239
31. DATE FILED (Month, Day, Year): APR 20 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Landrum

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11019

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Larry Hughes
2. DATE OF DEATH: MONTH 4 DAY 13 YEAR 89
3. TIME OF DEATH: 1/9 AM M
4. SOCIAL SECURITY NUMBER: 216-72-4815
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 33 yo YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10/30/55
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): UNIVERSITY HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3804 HILLSDALE AVENUE
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): DAVID HUGHES
18. MOTHER'S NAME (First, Middle, Maiden Surname): HELEN HENSON
19a. INFORMANT'S NAME (Type/Print): DAVID HUGHES
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3804 HILLSDALE AVE.: BALTO., MD. 21207
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTERN STAR CEMETERY
20c. LOCATION — City or Town, State: BALTIMORE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy O. Dyett
22. NAME AND ADDRESS OF FACILITY: LEROY O. DYETT & SON F.H., INC. 4600 LIBERTY HEIGHTS AVENUE 21207

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Respiratory Arrest / Cardiac Arrest | — |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Hypoxia & Hypotension | 1 hr |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | ARDS | 2 days |
| DUE TO (OR AS A CONSEQUENCE OF): d. | Pulmonary Abusses | >4 days |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Partial bowel obstruction 2° to ileus

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: K.K. Heacock / Resident
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 4/13/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gregg L. Heacock 6308 Greenspring Ave; Balto MD 21209
31. DATE FILED (Month, Day, Year): 4/13/89 APR 21 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Lindsay

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11020
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages [illegible] be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Hutchinson Willian | | 2. DATE OF DEATH (Month / Day / Year): 4 / 4 / 89 | 3. TIME OF DEATH: 1135 P M |
| 4. SOCIAL SECURITY NUMBER: 223-14-6250 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4/15/10 |
| 8. BIRTHPLACE (State or Foreign Country) | | | |
| 9a. FACILITY NAME (If not institution, give street and number): University Maryland Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2021 Hollins St | 10f. ZIP CODE: 21223 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 8+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RETIRED | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Robert Hutchinson | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Virginia Nicks | | |
| 19a. INFORMANT'S NAME (Type/Print): WALTER DARDEN | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2021 HOLLINS STREET | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. AUBURN CEMETERY | 20c. LOCATION — City or Town, State: BALTO., MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lynette K. Jones | 22. NAME AND ADDRESS OF FACILITY: BROWN-THOMPSON F.H. P.O. BOX 4433 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Maxillary Sinus Squamous cell CA | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Lori Trommer Lori Trommer | | ▶ 4/4/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Univ Maryland hospital 22 S Greene St

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 6 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11021

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frank S. Howe — Frank S. Howe
2. DATE OF DEATH (Month, Day, Year): 04 02 89
3. TIME OF DEATH: 7:20 pM
4. SOCIAL SECURITY NUMBER: 165 24 5759
5. SEX: 1 ☑ M 2 ☐ F
6. AGE (In yrs. last birthday): 59 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1/15/30
8. BIRTHPLACE (State or Foreign Country): Penna.
9a. FACILITY NAME (If not institution, give street and number): Loch Raven VA Hosp
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore city
9c. COUNTY OF DEATH: Balto City

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore Essex
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☒ ND
10e. STREET AND NUMBER: 1605 Essextowne Circle
10f. ZIP CODE: 21221
10g. CITIZEN OF WHAT COUNTRY? U.S.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: Korean
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 — College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Driver
16b. KIND OF BUSINESS/INDUSTRY: Trucking Co.
17. FATHER'S NAME (First, Middle, Last): Frank Howe
18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Freed
19a. INFORMANT'S NAME (Type/Print): Elizabeth Howe, Wife
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1605 Essextown Circle Balto Md. 21221
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Memorial Gardens
20c. LOCATION — City or Town, State: Balto Co Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home PA, 1407 Old Eastern Ave. Balto Md. 21221

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Metastatic Adenocarcinoma
DUE TO (OR AS A CONSEQUENCE OF):
c. Pleural effusion
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: James [illegible]
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): 4/2/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): APR 4 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 11022

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles W. Hoyle
2. DATE OF DEATH (Month, Day, Year): 4 7 89
3. TIME OF DEATH: 5:55 P M
4. SOCIAL SECURITY NUMBER: 240-30-7926
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 65 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 8-12-23
8. BIRTHPLACE (State or Foreign Country): N.C.
9a. FACILITY NAME (If not institution, give street and number): Sinai
9b. CITY, TOWN OR LOCATION OF DEATH: Balto.
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Balto.
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2711 Ruscombe Lane
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver
16b. KIND OF BUSINESS/INDUSTRY: Assoc. Transport
17. FATHER'S NAME (First, Middle, Last): Blaine Hoyle
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mildred Duff
19a. INFORMANT'S NAME (Type/Print): Georgianna Hoyle
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2711 Ruscombe Lane Balto., MD 21215
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify):
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MD NAT. MEM. PK.
20c. LOCATION — City or Town, State: Laurel, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: March F.H. West, 4300 Wabash Ave

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiac Arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): b. | V. Tach | 1 hour |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Ischemic Heart Disease | years |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal Disease, Liver Disease, Diabetes

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
25. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: 9424
29d. DATE SIGNED (Month, Day, Year): 4/7/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print):
31. DATE FILED (Month, Day, Year): APR 12 1989
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-18 Rev 1/89

88 11055

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11023

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ARBOR HOPEWELL
2. DATE OF DEATH (Month, Day, Year): 04-12-89
3. TIME OF DEATH: 5:15 PM
4. SOCIAL SECURITY NUMBER: 212-18-8722
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 09/18/18
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, MD
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 734 N. CAREY STREET
10f. ZIP CODE: 21217
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): THOMAS HOPEWELL
18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN
19a. INFORMANT'S NAME (Type/Print): PAULINE HOPEWELL SAUNDERS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3916 W. COLDSPRING LANE; BALTO. MD 21215
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. AUBURN
20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy O. Dyett
22. NAME AND ADDRESS OF FACILITY: LEROY O. DYETT & SON F.H., INC. 4600 LIBERTY HGTS AVE. 21207

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY FAILURE

DUE TO (OR AS A CONSEQUENCE OF): b. PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c. TUBERCULOSIS

DUE TO (OR AS A CONSEQUENCE OF): d.

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): 04/12/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): AMA FILE, Liberty Medical Center
31. DATE FILED (Month, Day, Year): APR 21 1989
32. REGISTRAR'S SIGNATURE: Julia Henderson-Randall

OHMH-16 Rev 1/89

88 11053

Items 2 [illegible] Film G650 4/21/89 CC
per R.S.

Item # 9b&10c per FH film 650 4/12/89fj

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11024

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Essie M. Humphreys | | | 2. DATE OF DEATH (Month, Day, Year): 4-6-89 | 3. TIME OF DEATH: 10:20AM M |
| 4. SOCIAL SECURITY NUMBER: 216-07-6307 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 77 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12/15/1911 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 4220 White Avenue | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: Baltimore | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 4220 White Avenue/Balto. MD | 10f. ZIP CODE: 21206 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): seamstress | 16b. KIND OF BUSINESS/INDUSTRY: clothing manufacturer | |
| 17. FATHER'S NAME (First, Middle, Last): Osbin Robinson | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Clemetine Ryan | | |
| 19a. INFORMANT'S NAME (Type/Print): Joyce Macek | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 3/ Box 145I, Laurel, Del. 19956 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Crematory | 20c. LOCATION — City or Town, State: Silver Spring, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Walter Brooks Bradley , Inc. 2134 Willow Spring Road/Balto. MD 2122 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute butebarbitol intoxication | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| ☒ YES 2 ☐ NO | ☒ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY: 4/6/89 M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO | 29d. DESCRIBE HOW INJURY OCCURED: Subject used drugs |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 4220 White Ave. Balto. City MD | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | OCME | 4-7-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
VC Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 10 1989 | [signature] |

DHMH-16 Rev 1/89

89 11025

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES EDWARD HYDE
2. DATE OF DEATH: MONTH 4 DAY 7 YEAR 89
3. TIME OF DEATH: 1157 A M
4. SOCIAL SECURITY NUMBER: 213-14-2094
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3/28/14
8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): UNIVERSITY HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 828 EDMONDSON AVE
10f. ZIP CODE: 21201
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 7TH GRADE — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CRANE OPERATOR
16b. KIND OF BUSINESS/INDUSTRY: BETHLEHAM STEEL
17. FATHER'S NAME (First, Middle, Last): MATTHEW WILLIAMS
18. MOTHER'S NAME (First, Middle, Maiden Surname): IDA UNKNOWN
19a. INFORMANT'S NAME (Type/Print): MRS. EVELYN HYDE
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 828 EDMONDSON AVE. BALTO. MD. 21201
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VET CEM.
20c. LOCATION — City or Town, State: OWINGS MILLS, MD, 21117
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gary L. Rollins
22. NAME AND ADDRESS OF FACILITY: NUTTER FUNERAL HOMES, INC, 2501 GWYNNS FALLS PKWY. BALTO. MD. 2121[illegible]

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | ACUTE MYOCARDIAL INFARCTION | 8 HRS. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | SEVERE CORONARY ARTERY DISEASE | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD
29c. LICENSE NUMBER: D36095
29d. DATE SIGNED (Month, Day, Year): ▶ 4/7/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KENT KESTON MD UNIV. HOSPITAL BALTIMORE MD 21201
31. DATE FILED (Month, Day, Year): APR 10 1989
32. REGISTRAR'S SIGNATURE: [illegible] Davidson-Randall

ONMH-16 Rev 1/89

Item # 19a per FH film 650 4/20/89fj

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11026 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached from page 4 as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LENA ISAACSON (LENA ISAACSON) | | | 2. DATE OF DEATH (Month, Day, Year): 4 7 89 | 3. TIME OF DEATH: 715 PM |
| 4. SOCIAL SECURITY NUMBER: 213 03 6334 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): MAR. 24, 1911 | 8. BIRTHPLACE (State or Foreign Country): PENNA. |
| 9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 2323 MICAROL RD. | | 10f. ZIP CODE: 21209 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: AT HOME |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): MAX CAPLAN | 18. MOTHER'S NAME (First, Middle, Maiden Surname): SARAH ZABLONSKY |
| 19a. INFORMANT'S NAME (Type/Print): HARRY ~~CAPLAN~~ Isaacson | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2323 MICAROL RD. BALTO., MD 21209 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BETH EL MEM. PARK | 20c. LOCATION — City or Town, State: RANDALLSTOWN. MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jay Levin | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. METASTATIC COLON CANCER | 13 YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER: D35606 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/7/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SAMUEL ZYGLER MD 711 W 40 ST BALT MD 21211 | | |
| 31. DATE FILED (Month, Day, Year): APR 12 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11027
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): John R. Imbraguglio | | | 2. DATE OF DEATH (Month, Day, Year): April 8, 1989 | 3. TIME OF DEATH: 6:50 (A/M) |
| 4. SOCIAL SECURITY NUMBER: 216-10-0916 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Feb. 19, 1919 | 8. BIRTHPLACE (State or Foreign Country): U.S.A. |
| 9a. FACILITY NAME (If not institution, give street and number): Loch Raven Veterans Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1218 Gittings Avenue | | 10f. ZIP CODE: 21239 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Army WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9Yrs; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk | 16b. KIND OF BUSINESS/INDUSTRY: A&P | |
| 17. FATHER'S NAME (First, Middle, Last): Nicholas Imbraguglio | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Gloroso | |
| 19a. INFORMANT'S NAME (Type/Print): Agatha Imbraguglio | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1218 Gittings Avenue Baltimore, Md. 21239 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cem. 4/11/89 | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Milton J. Knight Jr. Milton J. Knight Jr. | | 22. NAME AND ADDRESS OF FACILITY: 5305 HARFORD RD. BALTO. MD. 21214 21214 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Acute Myocardial Infarction | 1½ hours |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Coronary Artery Disease | Years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes, Chronic Renal Failure, Pneumonia; Hx of MI HTN

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Bruce L. Rollman MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/18/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Bruce L. Rollman Loch Raven VA Hosp Balt MD | | |
| 31. DATE FILED (Month, Day, Year): APR 11 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 11027

89 11028

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Raymond | | Iozzi | 4 / 1 / 89 | 9:02 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-30-4717 | 1 [X] M 2 [ ] F | 54 YRS. | | | Jan 2 1935 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 1144 Dundalk Avenue | Baltimore | BAlto. City |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | | BAltimore | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1144 Dundalk Avenue | 21224 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 8th | | Inspector | BAltimore City |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Guido Iozzi Sr. | Louise Decerbo |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Peggy Iozzi | 1144 Dundalk Ave. BAlto. Md. 21224 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Oak Lawn Cemetery | BAlto. Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Connelly Funeral Home | 212222 ConnellyFuneralHome of Dundalk |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hanging | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined | 3-31-89 est. | M | 1 [ ] YES 2 [X] NO | subject hanged himself |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Home | 1144 Dundalk Ave., Balto., Md. |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin MD | OCME | ▶ 4-1-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Julia C. Goodin, M.D. 111 Penn St., Balto., Md. 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 4 1989 | Julia Davidson-Kendall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11029

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MINNIE L. Isekoff | | 2. DATE OF DEATH (Month, Day, Year): 4 3 89 | 3. TIME OF DEATH: 9:20P M |
| 4. SOCIAL SECURITY NUMBER: 219-16-5054 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12-18-00 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Levindale | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 133 SLADE AVE | 10f. ZIP CODE: 21208 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES XX | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ~~Clerical~~ HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: AT HOME | |
| 17. FATHER'S NAME (First, Middle, Last): MICHAEL LAMPE | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ETTA SIEGEL | |
| 19a. INFORMANT'S NAME (Type/Print): ETHEL ANNENBERG | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1 E. UNIVERSITY PKWY Baltimore, Md. 21218 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARLINGTON CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jack B. Levinson | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. PNEUMONIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. SENILE DEMENTIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. PARKINSONISM | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D25610 | ▶ 4.4.89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SETH HOWARD, M.D. LEVINDALE, 2434 W. BELVEDERE AVE, BALTIMORE, MD. 21215

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 07 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11030

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 4 must be completed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): James E. Irby Sr. | | | 2. DATE OF DEATH (Month, Day, Year): 5-2-89 | 3. TIME OF DEATH: 1P A M |
| 4. SOCIAL SECURITY NUMBER: 214-44-1394 | 5. SEX: 1 M 2 F | 6. AGE (In yrs. last birthday): 43 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4-28-45 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTO |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| 10e. STREET AND NUMBER: 908 WICKLOW ROAD | | 10f. ZIP CODE: 21229 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 8+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNKNOWN | 16b. KIND OF BUSINESS/INDUSTRY: DISABLED |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): ALEXANDER IRBY | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LEONA SHEPPARD |
| 19a. INFORMANT'S NAME (Type/Print): LEONA IRBY | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 908 WICKLOW ROAD/BALTIMORE, MD 21229 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 Burial 2 Cremation 3 Removal from State 4 Donation 8 Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTERN STAR CEMETERY | 20c. LOCATION — City or Town, State: CATONSVILLE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warner | 22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Esophageal Varices | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Cirrhosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Narcotic Dependency CA. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Suicide | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA; OTHER: 4 Nursing Home 5 Residence 8 Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Arvind P. Dilella (Resident) | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/2/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 90 Caton ave (SAH) Baltimore Md | | |
| 31. DATE FILED (Month, Day, Year): MAY 5 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

Items 23a thu 28f Per M.E. FilmG652 6/23/89 CG

89 11031

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| William | Jones | 4-13-89 | 2:40PM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-03-7850 | XX M 2 ☐ F | 52 YRS. | | | 08-14-36 | BALTO., MD. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Bon Secour Hospital | Baltimore City | BALTIMORE CITY |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | BALTIMORE CITY | BALTIMORE | XX 1 YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 2767 WEST NORTH AVENUE | 21217 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| XX 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 X NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | DISABLED | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| WALLACE JONES SR. | GERTRUDE TURNER |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| RUTH L. JONES HOOPER | 1926 W. BALTIMORE STREET (21223) |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | ARBUTUS MEMORIAL PK. | BALTIMORE, MARYLAND |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Lynette K. Jones | BRWON-THOMPSON F.H. P.O. BOX 4433 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ~~Fatty liver~~ Drowning | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ~~Chronic alcoholism~~ | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizure disorder and fatty liver due to chronic alcoholism

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XX 1 YES 2 ☐ NO | XX 1 YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| XX 1 YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 XX ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| XX 1 Natural 2 XX Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 4/13/89 | M | 1 ☐ YES 2 XX NO | Subject collapsed in bath tub |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Home | 2767 W. North Ave. Balto. City, Md. |

| 29a. CERTIFIER (Check only one) | |
|---|---|
| 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. | |

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin M.D. | OCME | 4-14-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 18 1989 | Julia Davidson-Landers |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

68 11031

89 11032

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Earldine Jackson | | 2. DATE OF DEATH (Month / Day / Year): 5 / 10 / 89 | 3. TIME OF DEATH: 7:40 PM |
| 4. SOCIAL SECURITY NUMBER: 220-30-6216-A | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Oct 20 1907 |
| 8. BIRTHPLACE (State or Foreign Country): VIRGINIA | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Deaton Hosp. + Medical Center | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH: NONE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 611 South CHARLES ST | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ✓ / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSE KEEPER | 16b. KIND OF BUSINESS/INDUSTRY: DOMESTIC |
| 17. FATHER'S NAME (First, Middle, Last): EUGENE JACKSON | 18. MOTHER'S NAME (First, Middle, Maiden Surname): OPHELIA LEWIS | |
| 19a. INFORMANT'S NAME (Type/Print): ANNIE BRANCH | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 524 North PAYSON ST BALT. MD. | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SECOND ELAM BAPTIST CH | 20c. LOCATION — City or Town, State: VIRGINIA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edward Forrest | 22. NAME AND ADDRESS OF FACILITY: FORREST BROS FUNERAL HOME | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Sepsis | 48hrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | URINARY TRACT SYMPTOMS | 48hrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia
Seizure Disorder

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D14622 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/11/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): 601 S. Charles St. Balto, Md 21201 | | |
| 31. DATE FILED (Month, Day, Year): MAY 26 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davison Rodgers | |

DHMH-16 Rev 1/89

88 11035

89 11033

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWARD WALDRON JACKSON, SR.
2. DATE OF DEATH (Month, Day, Year): 04 22 89
3. TIME OF DEATH: 6:15 p M
4. SOCIAL SECURITY NUMBER: 212-05-8127
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 10 10 14
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Deaton Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2337 Annapolis Road
10f. ZIP CODE: 21230
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th grade; College (1-4 or 6+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk
16b. KIND OF BUSINESS/INDUSTRY: Glass Manufacturing
17. FATHER'S NAME (First, Middle, Last): Edward Waldron Jackson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Gerke
19a. INFORMANT'S NAME (Type/Print): Mary E. Jackson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2337 Annapolis Road Baltimore, Md. 21230
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park
20c. LOCATION — City or Town, State: Elkridge, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis — DUE TO (OR AS A CONSEQUENCE OF): — Approximate Interval Between Onset and Death: approx 1-2 days

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST:
b. Infected sacral decubiti, possible pneumonia on transfer at present — DUE TO (OR AS A CONSEQUENCE OF):
c. Hemiplegia — DUE TO (OR AS A CONSEQUENCE OF):
d. CVA

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: history of emphysema

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 6 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 6 [ ] Could not be determined
26a. DATE OF INJURY (Month, Day, Year):
26b. TIME OF INJURY:
26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
26d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Malinda MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 4/23/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): P Malinda MD 120 S Greene St, Baltimore MD — University of Maryland Family Health Center
31. DATE FILED (Month, Day, Year): APR 24 1989
32. REGISTRAR'S SIGNATURE: [signature]

DNMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| GARY | E. | JACKSON | 4 / 14 / 89 | 12:16 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-62-3117 | 1 [X] M 2 [ ] F | 35 YRS. | | | 12-15-53 | MD |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 1612 E. Preston St. | Baltimore | |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | | BALTIMORE CITY | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1612 EAST PRESTON STREET | 21213 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12th Grade | | Unemployed | NA |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| VINCENT JACKSON | DORIS A. DAVIS |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| PAULA A. JACKSON | 1643 N. WOLF STREET/ BALTIMORE, MD. 21213 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | MOUNT ZION CEMETERY | LANSDOWNE, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ William C. March | WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cirrhosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Chronic alcoholism | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [X] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY | 26c. INJURY AT WORK? | 26d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin M.D. | OCME | ▶ 4-15-89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | |
|---|---|
| Julia C. Goodin, M.D. | 111 Penn St., Balto., MD 21201 |

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 18 1989 | Julia Davidson-Randolph |

DNMN-16 Rev 1/89

89 11035

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): FAITH V. JAMES | | 2. DATE OF DEATH (Month, Day, Year): APRIL 13, 1989 | 3. TIME OF DEATH: 11:30 PM |
| 4. SOCIAL SECURITY NUMBER: 214-86-2407 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 21 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 4/7/68 |
| 8. BIRTHPLACE (State or Foreign Country): MD | | | |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2106 HARFORD ROAD | 10f. ZIP CODE: 21218 | 10g. CITIZEN OF WHAT COUNTRY: USA | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES: NA | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED | 16b. KIND OF BUSINESS/INDUSTRY: NA | |
| 17. FATHER'S NAME (First, Middle, Last): CHARLES H. JAMES | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET RHODES | | |
| 19a. INFORMANT'S NAME (Type/Print): MARGARET FERGUSON | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2106 Harford Road/Baltimore, MD. 21218 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): KING MEMORIAL PARK CEMETERY | 20c. LOCATION — City or Town, State: RANDALLSTOWN, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Gaines | 22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE | | |

**TO BE COMPLETED BY PHYSICIAN MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | MULTI-ORGAN SYSTEM FAILURE | ~10 days |
| DUE TO (OR AS A CONSEQUENCE OF): b. | ADULT RESPIRATORY DISTRESS SYNDROME | ~3 WEEKS |
| DUE TO (OR AS A CONSEQUENCE OF): c. | PERIANAL ABSCESS AND SUSPECTED SEPSIS | ~3 WEEKS |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYIND PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph R. Tobin m.d. FELLOW, ANESTHESIOLOGY | 29c. LICENSE NUMBER: D35301 | 29d. DATE SIGNED (Month, Day, Year): ▶ April 13, 1989 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSEPH R. TOBIN M.D. 601 N. BROADWAY BALTIMORE, MD 21205 | | | |
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | 32. REGISTRAR'S SIGNATURE: [illegible] | | |

DHMH-16 Rev 1/89

89 11035

89 11036

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Carolyn S Jennings | | | 2. DATE OF DEATH: Month 4 Day 13 Year 89 | 3. TIME OF DEATH: 1230 A M |
| 4. SOCIAL SECURITY NUMBER: 214-03-2332 | 5. SEX: 1 M 2 F | 6. AGE (In yrs. last birthday): 84 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 8-9-04 | 8. BIRTHPLACE (State or Foreign Country): Mullins SC |
| 9a. FACILITY NAME (If not institution, give street and number): Inns of Evergreen NW | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore city | | 9c. COUNTY OF DEATH |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE City | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| 10e. STREET AND NUMBER: 3930 Duvall Ave | | 10f. ZIP CODE: 21216 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY: At Home |
| 17. FATHER'S NAME (First, Middle, Last): Aron Livingston | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna J McDuffie | | |
| 19a. INFORMANT'S NAME (Type/Print): Tyrea A Jennings | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3930 Duvall Ave Balto. MD 21216 | | |
| 20a. METHOD OF DISPOSITION: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Carmichael Cemetery | | 20c. LOCATION — City or Town, State: Mullins SC |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Marshall P Hayes | | 22. NAME AND ADDRESS OF FACILITY: Marshall P Hayes Funeral Home 638 N. Gilmore Street Balto MD 21217 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CVA | 3/89 |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. DUE TO (OR AS A CONSEQUENCE OF): | |
| | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA | OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | |
| 27. MANNER OF DEATH: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Kenneth M Zonies MD | D 20333 | 4/14/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): K. M. ZONIES MD 777 Reisterstown Rd Pikesville MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 21 1989 | Julia Dixon-Kendall |

DHMH-16 Rev 1/89

89 11037

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOSEPHINE M. JEPPI | | | 2. DATE OF DEATH (Month, Day, Year): 4-15-89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 218-68-6450 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 1-5-1906 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 1361 E. Northern Pkwy. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1361 E. Northern Pkwy. | 10f. ZIP CODE: 21239 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 Yrs. | College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: |

| | | | |
|---|---|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Frank Cimino | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine Cimino | |
| 19a. INFORMANT'S NAME (Type/Print): John A. Jeppi | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1361 E. Northern Pkwy., Baltimore, Md. 21239 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cem. 4-18-89 | 20c. LOCATION — City or Town, State: Balto., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Roy H. Cather Roy H. Cather | | 22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Atherosclerotic cardiovascular disease | 15 yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: David A. Goldscher | 29c. LICENSE NUMBER: D16770 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-17-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David A. Goldscher, M.D., Good Samaritan Hospital

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 11037

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11038
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): BABY GIRL JOHNSON

**2. DATE OF DEATH** (Month, Day, Year): 03 06 89

**3. TIME OF DEATH**: 18:50 M

**4. SOCIAL SECURITY NUMBER**: N/A

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 0 YRS. — IF UNDER 1 YEAR: MONTHS 0 DAYS 0 — IF UNDER 24 HRS.: HOURS 0 MIN. 49

**7. DATE OF BIRTH** (Month, Day, Year): 3/6/89 — 03-06-89

**8. BIRTHPLACE** (State or Foreign Country): Maryland.

**9a. FACILITY NAME** (If not institution, give street and number): St. Agnes hosp

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore

**9c. COUNTY OF DEATH**: Baltimore

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md.

**10b. COUNTY**: BALTIMORE

**10c. CITY, TOWN OR LOCATION**: Balto.

**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☒ NO

**10e. STREET AND NUMBER**: 7400 Lesada Dr.

**10f. ZIP CODE**: 21207

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: BLACK

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): N/A — College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): N/A

**16b. KIND OF BUSINESS/INDUSTRY**: N/A

**17. FATHER'S NAME** (First, Middle, Last):

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): DONNA JOHNSON

**19a. INFORMANT'S NAME** (Type/Print): DONNA JOHNSON

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7400 LESADA DRIVE, BALTIMORE, MARYLAND 21207

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): NEW CATHEDRAL CEMETERY

**20c. LOCATION — City or Town, State**: BALTIMORE, MARYLAND

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Leroy M. Witzke

**22. NAME AND ADDRESS OF FACILITY**: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES, 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Severe Prematurity — 10minutes

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☒ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☒ YES 2 ☐ NO

**26. PLACE OF DEATH** (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Nilgun Antmen Morris M.D

**29c. LICENSE NUMBER**:

**29d. DATE SIGNED** (Month, Day, Year): ▶ 3/6/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Nilgun Antmen MD. 1103 S. Queen st York, PA 17403

**31. DATE FILED** (Month, Day, Year): APR 24 1989

**32. REGISTRAR'S SIGNATURE**:

DHMH-16 Rev 1/89

Item:5,7 per Informant G-650
4-21-89 WH

89 11039

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| GEORGE | EARL | JOHNSON | 4 16 89 | 2:10 AM |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-16-6705 | 1 ☐ M 2 ☒ F | ~~83~~ 73 YRS. | | | 6-25-~~00~~15 | VA. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 927 N. Franklintown Rd. | Baltimore | |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD. | | BALTIMORE | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 508 BRIDGEVIEW RD. | 21225 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☒ YES 2 ☐ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| UNK | | UNKNOWN | NA |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| EDWARD E. JOHNSON | FANNIE |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| THEODORE GLENN | 3508 CLIFTON AVENUE BALTO. MD |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | CROWNSVILLE VA. CEMETERY | CROWNSVILLE, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Calvin L. Williams | WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease and chronic alcoholism | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| ☒ YES 2 ☐ NO | 1 ☒ YES 2 ☐ NO |
| Head Only | |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Scene |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin | OCME | ▶ 4-16-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Julia C. Goodin, M.D. 111 Penn St., Balto., MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 20 1989 | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11040
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Gregory V. Johnson | | | 2. DATE OF DEATH: MONTH 4 DAY 19 YEAR 89 | 3. TIME OF DEATH: 11:46 a M |
| 4. SOCIAL SECURITY NUMBER: 219-52-7924 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country): Md |
| 9a. FACILITY NAME (If not institution, give street and number): University Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3933 Cedardale Road | | 10f. ZIP CODE: 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): Irvin Johnson, Sr | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary F. Jordan | | |
| 19a. INFORMANT'S NAME (Type/Print): Mary F. Foster | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3933 Cedardale Road Balto, Md 21215 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Mem Park | | 20c. LOCATION — City or Town, State: Arbutus Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [illegible] | | 22. NAME AND ADDRESS OF FACILITY: March F.H. Catonsville | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio pulmonary Arrest | 20 min |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Perforated Appendix, Periappendiceal Abscess, Cecal Necrosis
HIV Seropositivity, History of Aortic Insufficiency
requiring Aortic Valve Replacement

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Daniel J Rack MD (Intern) | | ▶ 4/19/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Daniel J Rack MD, Dept of Surgery, Univ. of MD Hospital, Baltimore MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 24 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

1571

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11041
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) John Russell Johnson / John R Johnson | | | 2. DATE OF DEATH (Month, Day, Year) April 14 1989 | 3. TIME OF DEATH 10:16 p M |
| 4. SOCIAL SECURITY NUMBER 263385783 | 5. SEX 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday) 72 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year) Nov. 18, 1916 | 8. BIRTHPLACE (State or Foreign Country) Florida |
| 9a. FACILITY NAME (If not institution, give street and number) Homewood Hospital Center, South | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH — |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE Maryland | 10b. COUNTY Harford | 10c. CITY, TOWN OR LOCATION Edgewood | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER 2301 Perry Avenue | | 10f. ZIP CODE 21040 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES WWII-Korea | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Safety Officer | 16b. KIND OF BUSINESS/INDUSTRY US-govt. | |
| 17. FATHER'S NAME (First, Middle, Last) John S. Johnson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie E. Blackburn | |
| 19a. INFORMANT'S NAME (Type/Print) Nila M. Johnson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2301 Perry Avenue, Edgewood, Md. 21040 | |
| 20a. METHOD OF DISPOSITION 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Harford Memorial Gardens | 20c. LOCATION — City or Town, State Aldino, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Howard K McComas III | | 22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Failure | 1 mo |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Lung Cancer - non small cell | 1 year |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Hypercoagulability | 1 year |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER Rebecca Love MD | 29c. LICENSE NUMBER D34688 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/15/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Rebecca Love Homewood Hospital 28th + Charles St 21218 | | |
| 31. DATE FILED (Month, Day, Year) APR 17 '89 | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11042
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MICHAEL JOHNSON | | | 2. DATE OF DEATH (Month, Day, Year): 4 16 89 | 3. TIME OF DEATH: 12:35 P M |
| 4. SOCIAL SECURITY NUMBER: 217-56-6232 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 35 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 10-31-53 | 8. BIRTHPLACE (State or Foreign Country): BALTO., MD |
| 9a. FACILITY NAME (If not institution, give street and number): 1621 W. Lexington St. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: BALTO. CITY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE CITY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1621 W. LEXINGTON STREET | | 10f. ZIP CODE: 21223 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNKNOWN | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): PARIS JOHNSON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNIE COTTON | |
| 19a. INFORMANT'S NAME (Type/Print): BRENDA FOSTER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 NORTH CATHERINE STREET (21223) | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK | 20c. LOCATION — City or Town, State: BALTO., MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lynette K. Jones | | 22. NAME AND ADDRESS OF FACILITY: BROWN-THOMPSON F.H. P.O. BOX 4433 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Gunshot wound to head | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) scene | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 4-16-89 | 28b. TIME OF INJURY: 12:26P M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: subject shot | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): house | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1621 W. Lexington St. | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-17-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James A. Kaplan, M.D. 111 Penn Street Baltimore, MD 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 18 1989 | 32. REGISTRAR'S SIGNATURE |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11043
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Myers Johnson, Sr. | | 2. DATE OF DEATH (Month, Day, Year): 4-14-89 | 3. TIME OF DEATH: 2:55AM M |
| 4. SOCIAL SECURITY NUMBER: 247-24-0523 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2/07/20 |
| 8. BIRTHPLACE (State or Foreign Country): SC | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 718 Cator Avenue | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 718 CATOR AVENUE | 10f. ZIP CODE: 21218 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BETH STEEL | 16b. KIND OF BUSINESS/INDUSTRY: RETIRED | |
| 17. FATHER'S NAME (First, Middle, Last): MAL JOHNSON | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CARRIE GASTON BUTLER | | |
| 19a. INFORMANT'S NAME (Type/Print): HELEN JOHNSON | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 718 CATOR AVENUE BATLO., MD 21218 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): KING MEMORIAL PARK | 20c. LOCATION — City or Town, State: RANDALLSTOWN, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William Monk | 22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema and Kidney Failure

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | INQUIRY | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year) ▶ 4-14-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin,M.D. 111 Penn Street,Baltimore,MD 21201 VC

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 18 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 11044

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Clarence J. Jones
2. DATE OF DEATH (Month, Day, Year): 4/20/89
3. TIME OF DEATH: 3:50 P M
4. SOCIAL SECURITY NUMBER: 213-05-4022
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5/3/05
8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): LOCH RAVEN VETERAN CEMETERY
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

**RESIDENCE OF DECEDENT**

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2810 GRANTLEY STREET
10f. ZIP CODE: 21229
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): UNKNOWN — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LAUNDRY WORKER/TRUCK DRIVER
16b. KIND OF BUSINESS/INDUSTRY: RETIRED
17. FATHER'S NAME (First, Middle, Last): GEORGE CARTER
18. MOTHER'S NAME (First, Middle, Maiden Surname): AMELIA JONES
19a. INFORMANT'S NAME (Type/Print): CLIFTON LOCKMAN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 311 NORTH MOUNT STREET/BALTIMORE, MD 21223
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VA. CEMETERY
20c. LOCATION — City or Town, State: OWINGS MILLS, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin L. Williams
22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiopulmonary Arrest | 10 Min. |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Pneumonia | 7 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Staph. aureus Sepsis (Methicillin-resistant) | 1-2 wk. |
| d. | Urinary Tract Infection with Staph. aureus | 1-2 wk. |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Benign prostatic hypertrophy; Dementia, Chronic

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): None
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one) — 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: J. Morrow, MD
29c. LICENSE NUMBER: U. of Maryland Med. Resident
29d. DATE SIGNED (Month, Day, Year): 4/20/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John F. Morrow, M.D., Department of Medicine, University Hospital, Baltimore, MD 21201
31. DATE FILED (Month, Day, Year): APR 24 1989
32. REGISTRAR'S SIGNATURE: Theodore Rudacs

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11045
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Elizabeth H. Jones

**2. DATE OF DEATH** (Month, Day, Year): 4 4 1989

**3. TIME OF DEATH**: 7 [illegible] P M

**4. SOCIAL SECURITY NUMBER**: 218 34 0247

**5. SEX**: 1 ☐ M 2 ☑ F

**6. AGE** (In yrs. last birthday): 90 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 3-29-99

**8. BIRTHPLACE** (State or Foreign Country): Md.

**9a. FACILITY NAME** (If not institution, give street and number): Roland Park Place

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore Maryland

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 ☑ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 830 W 40th Street

**10f. ZIP CODE**: 21211

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Homemaker

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): Henry Nelson Hanna

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Alice Jeffery

**19a. INFORMANT'S NAME** (Type/Print): Mr. George P. Dix

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26619 Haney Ave. Damascus, Md. 20872

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Presbyterian Church Cemetery

**20c. LOCATION — City or Town, State**: Churchville, Md.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Sherman Chaney Jr

**22. NAME AND ADDRESS OF FACILITY**: MITCHELL-WIEDEFELD HOME, INC. 6500 York Road Baltimore, Md. 21212

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Acute Myocardial Infarction | 1 Hr |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | ASCVD | 20 yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**: Parkinsons Disease

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year):

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**:

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify):

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Gregory L. Walker MD

**29c. LICENSE NUMBER**: MD 25662

**29d. DATE SIGNED** (Month, Day, Year): ▶ 4/5/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Gregory L. Walker, MD 3300 N. Calvert St. Baltimore, Md. 21218

**31. DATE FILED** (Month, Day, Year): APR 11 1989

**32. REGISTRAR'S SIGNATURE**: Lilia Tasilan-Randall

OHMH-16 Rev 1/89

89 11046

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

4

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ETHEL JONES
2. DATE OF DEATH: MONTH 4 DAY 17 YEAR 89
3. TIME OF DEATH: 5:45 PM
4. SOCIAL SECURITY NUMBER: 215-32-1999
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 83 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7 30 1905
8. BIRTHPLACE (State or Foreign Country): Va.
9a. FACILITY NAME (If not institution, give street and number): Bon Secours Hosp.
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: none

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: none
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 823 N. Calhoun St.
10f. ZIP CODE: 21217
10g. CITIZEN OF WHAT COUNTRY? U.S.A
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Joe Jones
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Jones
19a. INFORMANT'S NAME (Type/Print): Ned Jones
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2914 Ellicott Dr. Balto., Md.
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Md. National Mem. Pk
20c. LOCATION — City or Town, State: Laurel, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Juanita D. Morton
22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons, 1701 Laurens St.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Respiratory arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Cerebrovascular tumor | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Renal cell carcinoma | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Severe anemia. Cerebral thrombosis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Marek Krouna
29c. LICENSE NUMBER: D 185476
29d. DATE SIGNED (Month, Day, Year): ▶ 4/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 944 N. Carey St. Balto Md 21217
31. DATE FILED (Month, Day, Year): APR 18 1989
32. REGISTRAR'S SIGNATURE: [illegible]

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 of 2 sheets
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): George Jones , Sr | | | 2. DATE OF DEATH (Month, Day, Year): 4-20-89 | 3. TIME OF DEATH: 11:08PM M |
| 4. SOCIAL SECURITY NUMBER: 218-28-4894 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 58 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9 21 1930 | 8. BIRTHPLACE (State or Foreign Country): Ga |
| 9a. FACILITY NAME (If not institution, give street and number): Druid Hill Park | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 4618 Park Heights Avenue | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY? U S A |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Charles Jones, Sr | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Black |
| 19a. INFORMANT'S NAME (Type/Print): Helen Jones | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1818 Woodyear St Balto, Md 21216 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park | 20c. LOCATION — City or Town, State: Arbutus, Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Willie Edmond | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Arteriosclerotic cardiovascular disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) in auto | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 25a. DATE OF INJURY (Month, Day, Year) | 25b. TIME OF INJURY M | 25c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-21-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin,M.D. | 111 Penn Street,Baltimore,MD 21201 vc | |
| 31. DATE FILED (Month, Day, Year): APR 24 1989 | 32. REGISTRAR'S SIGNATURE: Julia Goodin-Rodnes | |

OHMH-16 Rev 1/89

89 11048

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Tonia M. Jordan | | | 2. DATE OF DEATH (Month, Day, Year): 4-18-89 | 3. TIME OF DEATH: 11:15AM M |
| 4. SOCIAL SECURITY NUMBER: 214-88-3504 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 25 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9-13-63 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): 1644 Cliftview Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1644 CLIFTVIEW AVENUE | | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNKNOWN | 16b. KIND OF BUSINESS/INDUSTRY: NA | |
| 17. FATHER'S NAME (First, Middle, Last): EDWARD CURBEAN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MYRTIE JORDAN | |
| 19a. INFORMANT'S NAME (Type/Print): MYRTIE ROSE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1644 Cliftview Avenue/Baltimore, MD. 21213 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): KING MEMORIAL PARK CEMETERY | 20c. LOCATION — City or Town, State: RANDALLSTOWN, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Anthony E. Ward Jr. | | 22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Stab wound of left chest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide ☒ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 4-18-89 | 28b. TIME OF INJURY: 10:00P | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO | 28d. DESCRIBE HOW INJURY OCCURED: subject stabbed |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): house | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 2232 Calvert Street |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. M.D. | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-19-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Mario F. Golle,Jr.,M.D. 111 Penn Street,Baltimore,MD 21201 vc

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 24 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landeau |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11049
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): MARROCCO, JOSEPH

**2. DATE OF DEATH** (Month, Day, Year): 4 / 16 / 89

**3. TIME OF DEATH**: 5:15 PM

**4. SOCIAL SECURITY NUMBER**: 214-09-7181

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 83 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 11 27 05

**8. BIRTHPLACE** (State or Foreign Country): Brazil

**9a. FACILITY NAME** (If not institution, give street and number): FSKMC

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore

**9c. COUNTY OF DEATH**: Baltimore

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD

**10b. COUNTY**: –

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 [X] YES 2 [ ] NO

**10e. STREET AND NUMBER**: 305 Cornwall Street

**10f. ZIP CODE**: 21224

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 6th
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Laborer

**16b. KIND OF BUSINESS/INDUSTRY**: Distillery

**17. FATNER'S NAME** (First, Middle, Last): Frank Marrocco

**18. MOTNER'S NAME** (First, Middle, Maiden Surname): Maria Raspa

**19a. INFORMANT'S NAME** (Type/Print): Assunta DeMatteo

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14010 Fox Land Rd., Phoenix, Md. 21131

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Sacred Heart of Jesus Cemetery

**20c. LOCATION — City or Town, State**: Baltimore, Md.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Ann S. Matthews

**22. NAME AND ADDRESS OF FACILITY**: Matthews Funeral Home
3021 Eastern Avenue, Baltimore, Md.21224

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Septic Shock

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. CVA

DUE TO (OR AS A CONSEQUENCE OF):

c. Subendocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):

d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [ ] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [ ] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 5 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Grace A. Cardy Housestaff

**29c. LICENSE NUMBER**: D 35763

**29d. DATE SIGNED** (Month, Day, Year): ▶ 4-16-89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type/Print)

**31. DATE FILED** (Month, Day, Year): APR 21 1989 Julia

**32. REGISTRAR'S SIGNATURE**: Teodoro Pandeata

DNMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11050
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VIOLA V JOY — VIOLA V. JOY
2. DATE OF DEATH (Month, Day, Year): 4 / 12 / 89
3. TIME OF DEATH: 0430 AM
4. SOCIAL SECURITY NUMBER: 213-09-6741
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4-01-04
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: --

**RESIDENCE OF DECEDENT**

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: LANSDOWNE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 146 CLYDE AVENUE
10f. ZIP CODE: 21227
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY: OWN HOME
17. FATHER'S NAME (First, Middle, Last): THOMAS ELLISON
18. MOTHER'S NAME (First, Middle, Maiden Surname): EMMA STINCHCOMB
19a. INFORMANT'S NAME (Type/Print): LEROY E. KAGLE
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 146 CLYDE AVENUE, LANSDOWNE, MARYLAND 21227
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MEADOWRIDGE CEMETERY
20c. LOCATION — City or Town, State: DORSEY, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES, 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiomyopathy | 3 months |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Hypertension | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Renal Insufficiency
Cerebral Vascular Accident
Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Eugene T. Finan M.D. House Staff
29c. LICENSE NUMBER: Housestaff St. Agnes
29d. DATE SIGNED (Month, Day, Year): 4-12-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Eugene T FINAN Jr. MD. 900 Caton Ave Balto, Md 21229
31. DATE FILED (Month, Day, Year): APR 24 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Lindsay

DHMH-18 Rev 1/89

89 11051

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): William A. JOYCE

**2. DATE OF DEATH** Month: 4 Day: 16 Year: 89

**3. TIME OF DEATH**: 2:45 PM

**4. SOCIAL SECURITY NUMBER**: 213-14-5020

**5. SEX**: 1 ☒ M 2 ☐ F

**6. AGE** (In yrs. last birthday): 76 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 6-24-12

**8. BIRTHPLACE** (State or Foreign Country): Md

**9a. FACILITY NAME** (If not institution, give street and number): Mercy Hospital

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 4509 St Georges Ave

**10f. ZIP CODE**:

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: Blk

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.):

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): William H. Joyce

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Mary Mitchell

**19a. INFORMANT'S NAME** (Type/Print): Maude T. Joyce

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4509 St Georges Ave Balto, Md 21212

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Loudon Park Cemetery

**20c. LOCATION — City or Town, State**: Balto, Md

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE** ▶ Maude T. Joyce

**22. NAME AND ADDRESS OF FACILITY**: March F. H. West 4300 Wabash Ave

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Respiratory Failure | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Chronic Obstructive Pulmonary Disease | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Renal Failure
Congestive Heart Failure

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☒ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☐ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year):

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**:

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify):

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Tony Hoad M.D.

**29c. LICENSE NUMBER**:

**29d. DATE SIGNED** (Month, Day, Year) ▶

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Dr. Tony Hoad — Mercy Hospital — 301 St. Paul A — Balt. Md 21220

**31. DATE FILED** (Month, Day, Year): 4/16/ APR 21 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Landeck

DHMH-16 Rev 1/89

89 11021

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11052
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should use as the burial-transit permit.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Jones - Baby Girl

**2. DATE OF DEATH** (Month, Day, Year): 04 05 - 89

**3. TIME OF DEATH**: 20:31 PM

**4. SOCIAL SECURITY NUMBER**:

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 1 day

IF UNDER 1 YEAR — MONTHS: ; DAYS:

IF UNDER 24 HRS. — HOURS: 2 ; MIN.: 20

**7. DATE OF BIRTH** (Month, Day, Year): 04-05-89

**8. BIRTHPLACE** (State or Foreign Country): Md; USA

**9a. FACILITY NAME** (If not institution, give street and number): University of Maryland Hospital

**9b. CITY, TOWN OR LOCATION OF DEATH**: 22 S. Greene Street Baltimore, Md 21201

**9c. COUNTY OF DEATH**: U.S.A

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md

**10b. COUNTY**: U.S.A

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 22. S. Greene Street

**10f. ZIP CODE**: 21201

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A

**11. MARITAL STATUS**: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: Black

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.)

**16b. KIND OF BUSINESS/INDUSTRY**

**17. FATHER'S NAME** (First, Middle, Last):

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Anita L. Jones

**19a. INFORMANT'S NAME** (Type/Print): ANITA JONES

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1931 Hollins St., Baltimore, Md. 21223

**20a. METHOD OF DISPOSITION**: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☒ Other (Specify) in-state removal

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place):

**20c. LOCATION — City or Town, State**

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ [signature]

**22. NAME AND ADDRESS OF FACILITY**: STATE ANATOMY BOARD, BALTO., MD. 21201

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Failure | 1 hour |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☒ YES 2 ☐ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☒ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

**26a. DATE OF INJURY** (Month, Day, Year):

**26b. TIME OF INJURY**: M

**26c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**26d. DESCRIBE HOW INJURY OCCURED**

**26e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify):

**26f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: [signature] M.D

**29c. LICENSE NUMBER**:

**29d. DATE SIGNED** (Month, Day, Year): ▶ 04-06-89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print):

**31.** APR 05 '89

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 11052

.., Baltimore, Md. 21223

ANATOMY BOARD, BALTO.., MD. 21201

V.A.-Loch Raven Hosp.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11053
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ~~JORDAN~~ BILLIE JORDAN | | | | 2. DATE OF DEATH MONTH 4 DAY 27 YEAR 89 | 3. TIME OF DEATH 1:30 A M |
| 4. SOCIAL SECURITY NUMBER 247 38 8624 | 5. SEX 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday) 60 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) 4/4/29 | 8. BIRTHPLACE (State or Foreign Country) S. CAROLINA |
| 9a. FACILITY NAME (If not institution, give street and number) V.A. HOSPITAL-LOCH RAVEN | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE MD. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER 700 W. 33rd ST.-APT. #3 | | 10f. ZIP CODE 21211 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5 +) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) HIRAM NEWTON JORDAN | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY ELLA ROSS | | | | |
| 19a. INFORMANT'S NAME (Type/Print) CAROL ANN JORDAN | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 W. 33rd ST., BALTIMORE, MD. 21211 | | | | |
| 20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 6 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY STATE ANATOMY BOARD, BALTO., MD. 21201 | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. progressive respiratory insufficiency | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. carcinoma, metastases to lung | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. squamous cell carcinoma of oropharynx | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

carcinoma, metastases to brain

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| FISHMAN MD | | ▶ 4/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARC FISHMAN MD Loch Raven VA Hospital

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 01 1989 | Julia Davidson-Landeau |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 ... the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director ... detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.**

88 11023

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11054

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be ... or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 ... use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): James HENRY Jackson Jr. | | | 2. DATE OF DEATH (Month / Day / Year): 5 / 1 / 89 | 3. TIME OF DEATH: 7:30 AM |
| 4. SOCIAL SECURITY NUMBER: 242 46 5809 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 41 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 10 24 1947 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 5310 GOODNOW ROAD | | 10f. ZIP CODE: 21206 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): STEAMSHIP TRADE | 16b. KIND OF BUSINESS/INDUSTRY: DISABLED | |
| 17. FATHER'S NAME (First, Middle, Last): JAMES H. JACKSON SR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): OLIVIA LEWIS | |
| 19a. INFORMANT'S NAME (Type/Print): OLIVIA RYLES | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1721 DURHAM STREET/BALTIMORE, MD 21213 | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John B. Johnson Jr. | | 22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Staphylococcal cellulitis | |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Candidiasis | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | (Due to) AIDS. | 2 yrs. |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia
Leukopenia

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Resident | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 5/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 301 St. Paul Place Baltimore, Md. 21202

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): 5/MAY 5 1989 | 32. REGISTRAR'S SIGNATURE: Linda Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11055
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Frances / Frances R. Jones | | | | 2. DATE OF DEATH (Month, Day, Year): 4-26-89 | 3. TIME OF DEATH: 9:20PM M |
| 4. SOCIAL SECURITY NUMBER: 216 34 3320 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 54 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 6/5/34 | 8. BIRTHPLACE (State or Foreign Country): N.C. |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Md. | 10b. COUNTY: Balto | 10c. CITY, TOWN OR LOCATION: Turners Station | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1 Fleming Dr. | | 10f. ZIP CODE: 21222 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teachers Aide | | 16b. KIND OF BUSINESS/INDUSTRY: Education | |
| 17. FATHER'S NAME (First, Middle, Last): Eolis H. Jones | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ardenia Beard | | | |
| 19a. INFORMANT'S NAME (Type/Print): Michelle Waddy | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 218 N. Luzerne Ave. Balto., Md. 21224 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hills | | 20c. LOCATION — City or Town, State: Balto., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James A. Morton | | 22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons 1701 Laurens St. Balto., Md.21217 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO — INQUIRY | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Margarita A. Korell | OCME | 4-27-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell,M.D. 111 Penn Street,Baltimore,MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 1 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89-11056
REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CHRISTOPHER C. JONES, SR. | | | 2. DATE OF DEATH (Month, Day, Year): APR 30 1989 | 3. TIME OF DEATH: 2:00A M |
| 4. SOCIAL SECURITY NUMBER: 197-16-3283 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 6/24/08 | 8. BIRTHPLACE (State or Foreign Country): VIRGINIA |
| 9a. FACILITY NAME (If not institution, give street and number): LeVindale | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTO. | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3424 St. Ambrose Ave | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES: | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LONGSHOREMAN | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNIE JONES | |
| 19a. INFORMANT'S NAME (Type/Print): ESTHER JONES | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3424 St. AMBROSE AVE, BALTO, MD 21215 | |
| 20a. METHOD OF DISPOSITION: X 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTERN STAR Cemetery | 20c. LOCATION — City or Town, State: CATONSVILLE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leroy Harris | 22. NAME AND ADDRESS OF FACILITY: Chapman + Harris F.H. 1701-03 McCulloh Street | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. METASTATIC PROSTATE CANCER | 2 YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURRED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: A J Lucco ATTENDING MD | 29c. LICENSE NUMBER: D30951 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5-1-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): AJ LUCCO MD; 2434 W. BELVEDERE AVE BALTO 21215-5299 | | |
| 31. DATE FILED (Month, Day, Year): MAY 3 - 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the ... physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be ... the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at ...**

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

89 11056

USA

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11057
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): MARIE C. JENNINGS — Marie Catherine Jennings

**2. DATE OF DEATH** Month: 04 Day: 25 Year: 89

**3. TIME OF DEATH**: 545 (a M)

**4. SOCIAL SECURITY NUMBER**: 218-42-6175

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 74 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 05 31 14

**8. BIRTHPLACE** (State or Foreign Country): Md.

**9a. FACILITY NAME** (If not institution, give street and number): UNION MEMORIAL HOSPITAL

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTIMORE CITY

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md.

**10b. COUNTY**: ----------

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 6912 Eastbrook Avenue

**10f. ZIP CODE**: 21224

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 6
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Housework

**16b. KIND OF BUSINESS/INDUSTRY**: At Home

**17. FATHER'S NAME** (First, Middle, Last): Adam DiMattei

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Ruita Dunnaway

**19a. INFORMANT'S NAME** (Type/Print): Elizabeth M. Pritchard

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 301 McMechen St. Apt. 626 Balto., Md. 21217

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Oak Lawn Cemetery

**20c. LOCATION — City or Town, State**: Eastwood, Balto. Co., Md.

**21. SIGNATURE OF FUNERAL BERVICE LICENSEE**: ▶ Charles S. Zeiler

**22. NAME AND ADDRESS OF FACILITY**: Charles S. Zeiler & Son Inc. 6224 Eastern Ave.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Massive myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. coronary artery disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☒ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: M L Z Collin MD

**29c. LICENSE NUMBER**:

**29d. DATE SIGNED** (Month, Day, Year): ▶ 4/25/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print)
M. L. Z. COLLIN MD.

**31. DATE FILED** (Month, Day, Year): APR 27 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

OHMH-15 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11058
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be ... by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page ... may be used for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be ...**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HILDA May JOHNSON | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 26, 1989 | 3. TIME OF DEATH: 12:10 P M |
| 4. SOCIAL SECURITY NUMBER: 219-10-6651 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Mar. 3, 1907 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: Street | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3617 Grier Nursery Rd. | | 10f. ZIP CODE: 21154 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waitress | 16b. KIND OF BUSINESS/INDUSTRY: Restaurant |
| 17. FATHER'S NAME (First, Middle, Last): Jesse James Brent | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ella May Davis | |
| 19a. INFORMANT'S NAME (Type/Print): Vida Hedrick | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3615 Grier Nursery Rd., Street, MD 21154 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreladd Memorial Park | 20c. LOCATION — City or Town, State: Parkville, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. George Altenburg | | 22. NAME AND ADDRESS OF FACILITY: ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balitmore, MD 21214 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SEPSIS | 24° |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. LIVER DISEASE - Chronic Active Hepatitis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Urinary Tract Infection
Cholelithiasis

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: William R. Bell, Ph.D., M.D. | 29c. LICENSE NUMBER: Maryland D05732 | 29d. DATE SIGNED (Month, Day, Year): ▶ April 26, 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
| 31. DATE FILED (Month, Day, Year): MAY 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Kenadee | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11059 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JENNIE JENKINS | | 2. DATE OF DEATH (Month, Day, Year): 04/25/89 | 3. TIME OF DEATH: 6:36pm |
| 4. SOCIAL SECURITY NUMBER: 217-22-3661 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 81 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 12-27-07 |
| 8. BIRTHPLACE (State or Foreign Country): Md. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Hayes N.H. 3101 Garrison Blvd. | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 301 N. Payson St. | 10f. ZIP CODE: 21223 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): Willie Hill | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Jannie Woods | |
| 19a. INFORMANT'S NAME (Type/Print): Stella Chew | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 301 N. Payson St. Balto., Md. 21223 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Auburn Cem. | 20c. LOCATION — City or Town, State: Baltimore, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dala March | | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Ave. | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. POSSIBLE ACUTE SEVERE MYOCARDIAL INFARCTION. DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. HYPERTENSIVE ATHEROSCLEROTIC CARDIO-VASCULAR DISEASE. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARDIAC DYSRHYTHMIA. CONGESTIVE HEART FAILURE. CHRONIC OBSTRUCTIVE PULMONARY DISEASE. DEGENERATIVE JOINT DISEASE. GLAUCOMA.

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): N/A | 28b. TIME OF INJURY: N/A | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO N/A |
| 28d. DESCRIBE HOW INJURY OCCURED: N/A | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: F. Banegura M.D. | 29c. LICENSE NUMBER: D25065 | 29d. DATE SIGNED (Month, Day, Year): 04/25/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FABIO K. BANEGURA M.D. 7039 LIBERTY ROAD, BALTO, MD 21207

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 27 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landeau |

DHMH-16 Rev 1/89

89 11059

Items23a thu28f Per M.E. FilmG651 5/22/89 CG

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11060 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Antonio Johnson | | | 2. DATE OF DEATH (Month, Day, Year): 4-27-89 | 3. TIME OF DEATH: 5:37AM M |
| 4. SOCIAL SECURITY NUMBER: 218-82-2062 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 22 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9 13 1966 | 8. BIRTHPLACE (State or Foreign Country): Md |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 818 Wicklow Road | 10f. ZIP CODE: 21229 | 10g. CITIZEN OF WHAT COUNTRY? U S A | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Nathaniel Johnson, Jr | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Fay Knox |
| 19a. INFORMANT'S NAME (Type/Print): Fay Johnson | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 818 Wicklow Road Baltimore, Md 21229 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park | 20c. LOCATION — City or Town, State: Arbutus, Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dala March | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute combined drug (cocaine and morphine) and | |
| | DUE TO (OR AS A CONSEQUENCE OF): alcohol intoxication | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| X YES 2 ☐ NO | X YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 X Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 X Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 4/27/89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 X NO | 28d. DESCRIBE HOW INJURY OCCURED: Unknown |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Unknown | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Unknown |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A. Korell | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-27-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell,M.D. | 111 Penn Street,Baltimore,MD 21201 | VC |
| 31. DATE FILED (Month, Day, Year): MAY 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11061
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SALLIE B. JOHNSON
2. DATE OF DEATH (Month, Day, Year): 4-28-89
3. TIME OF DEATH: 5:00p M
4. SOCIAL SECURITY NUMBER: 216-12-6867
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 82 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4-28-07
8. BIRTHPLACE (State or Foreign Country): S.C.
9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORTION
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2117 SINCLAIR LANE
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd Grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Foster Care
16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): MORRIS MAYO
18. MOTHER'S NAME (First, Middle, Maiden Surname): ELLA LEMON
19a. INFORMANT'S NAME (Type/Print): MARY MACKEY
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2117 SINCLAIR LANE/BALTIMORE, MD. 21213
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PK. CEMETERY
20c. LOCATION — City or Town, State: ARBUTUS, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | ELECTHOLYTI MIBALOMIE | |
| DUE TO (OR AS A CONSEQUENCE OF): | DEHYDRATRON WA | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Bena Nagpal
29c. LICENSE NUMBER: NAGPAL BENA
29d. DATE SIGNED (Month, Day, Year): ▶
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): Bena Nagpal, CHURCH HOSPITAL
31. DATE FILED (Month, Day, Year): MAY 4 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 11061

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11062
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

20

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Norman M. Johnston | | 2. DATE OF DEATH (Month, Day, Year): 4-27-89 | 3. TIME OF DEATH: 10:20AM M |
| 4. SOCIAL SECURITY NUMBER: 217-02-7752 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4/7/09 |
| 8. BIRTHPLACE (State or Foreign Country): OHIO | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 1702 Park Avenue | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1702 PARK AVENUE | | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last) | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | |
| 19a. INFORMANT'S NAME (Type/Print): Kevin Murphy | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 91 Aquahart Rd., Glen Burnie, Md. 21061 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph B. Van Sant | | 22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Arteriosclerotic cardiovascular disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO — INQUIRY | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES [X] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home [X] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: [X] 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 8 [ ] Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) / 26b. TIME OF INJURY M / 26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 26d. DESCRIBE HOW INJURY OCCURED |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A. Korell | 29c. LICENSE NUMBER: ocme | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-27-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell,M.D. 111 Penn Street,Baltimore,MD 21201 VC | | |
| 31. DATE FILED (Month, Day, Year): MAY 05 '89 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Kendall | |

DHMH-16 Rev 1/89

S30!! 08

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11063
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Towanda Johnson | | | | | 2. DATE OF DEATH (Month, Day, Year): 4-22-89 (found) | 3. TIME OF DEATH: 9:53PM M |
| 4. SOCIAL SECURITY NUMBER: 212-86-3716 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 22 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): SEPT. 18-66 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 1215 Linworth Avenue | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1215 LINWORTH AVE. 1C | | 10f. ZIP CODE: 21218 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NURSINIG ASST. | 16b. KIND OF BUSINESS/INDUSTRY: NURSING | |
| 17. FATHER'S NAME (First, Middle, Last): ANTHONY JONHSON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): HAZEL LOVELIST | |
| 19a. INFORMANT'S NAME (Type/Print): HAZEL TURPIN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 521 WILLOW AVE. BALTO. M.D. 21218 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. ZION CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, M.D. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Laurence L Redd | | 22. NAME AND ADDRESS OF FACILITY: REDD FUNERAL SERVICE 1721 N MONROE | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple stab wounds and cutting wounds | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): UNKNOWN | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: subject stabbed | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1215 Linworth Avenue |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A Korell | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-23-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. | 111 Penn Street, Baltimore, MD 21201 vc | |
| 31. DATE FILED (Month, Day, Year): APR 26 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Pendarvis | |

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11064
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| Juluis | Johnson | 4-22-89(found) | 9:53PM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-06-3129 | 1 [X] M 2 [ ] F | 6 YRS. | | | 12/16/82 | MARYLAND |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 1215 Linworth Avenue #1C | Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | | BALTIMORE | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1215 LINWORTH AVE. 1C | 21218 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 3 | | NONE | N/A |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| CHARLES WILSON | TAWANA JOHNSON |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| HAZEL TURPIN | 521 WILLOW AVE. BALTO., M.D. 21218 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | MT. ZION CEMETERY | BALTIMORE, M.D. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Tuneese L Redd | REDD FUNERAL SERVICE 1721N MONROE |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple stab and cutting wounds | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| [X] YES 2 [ ] NO | [X] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | UNKNOWN | M | 1 [ ] YES 2 [X] NO | subject stabbed |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| home | 1215 Linworth Avenue |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | OCME | ▶ 4-23-89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | |
|---|---|
| James Kaplan,M.D. | 111 Penn Street,Baltimore,MD 21201 vc |

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 26 1989 | Julia Davidson-Rhodes |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11065

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ALETHA JACKSON | | | 2. DATE OF DEATH (Month, Day, Year): 4 3 89 | 3. TIME OF DEATH: 6 37 A M | |
| 4. SOCIAL SECURITY NUMBER: 217-20-1035A | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 86 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9-6-02 | 8. BIRTHPLACE (State or Foreign Country): South Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): Inn of Evergreen Central | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 140 West Lafayette Avenue | | 10f. ZIP CODE: 21217 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5th; College (1-4 or 5+): | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | | 15b. KIND OF BUSINESS/INDUSTRY: HOME | |
| 17. FATHER'S NAME (First, Middle, Last): BOB Brown | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): VERSEL GILYARD | | |
| 19a. INFORMANT'S NAME (Type/Print): Garcenia Smith | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2119 Hollin Street Baltimore, Md 21223 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEM. PARK | | 20c. LOCATION — City or Town, State: BALTIMORE, MD. 21227 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vernon R. Bailey | | 22. NAME AND ADDRESS OF FACILITY: NUTTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PARKWAY BALTIMORE, MARYLAND 21216 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiac arrythmia
DUE TO (OR AS A CONSEQUENCE OF):
b. Diabetes mellitus

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
c. arthritis
DUE TO (OR AS A CONSEQUENCE OF):
d. Chronic organic brain syndrome

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Contractures

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Moges Gebremariam
29c. LICENSE NUMBER: D18327
29d. DATE SIGNED (Month, Day, Year): ▶ 4/3/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): moges Gebremariam · 4660 Wilkens Ave Balto 21229

31. DATE FILED (Month, Day, Year): APR 5 1989
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11066
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): MARY Reed Jackson

**2. DATE OF DEATH** Month: 04 Day: 09 Year: 89

**3. TIME OF DEATH**: 0936 A M

**4. SOCIAL SECURITY NUMBER**: 212-38-9806

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 59 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 02 28 30

**8. BIRTHPLACE** (State or Foreign Country): VA

**9a. FACILITY NAME** (If not institution, give street and number): UNIVERSITY HOSPITAL

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTIMORE CITY

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: BALTIMORE

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 1204 N. LUZERNE AVENUE

**10f. ZIP CODE**: 21213

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: BLACK

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): HIGH SCHOOL
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): HOME SERVICE AID

**16b. KIND OF BUSINESS/INDUSTRY**: STATE DEPT. OF SOC SER.

**17. FATHER'S NAME** (First, Middle, Last): WALLY WILSON

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): MARY JOHNSON

**19a. INFORMANT'S NAME** (Type/Print): ANITA REED WATTS

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 510 N. PORT STREET/BALTO., MD 21205

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): KING MEMORIAL PARK

**20c. LOCATION — City or Town, State**: RANDALLSTOWN, MD

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE** ▶ [signature]

**22. NAME AND ADDRESS OF FACILITY**: WM. C. MARCH F/H 1101 E. NORTH AVENUE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not anter the moda of dying, auch as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on aach line.**

Approximate Interval Between Onset and Death

**IMMEDIATE CAUSE (Final disease or condition resulting in death)** →
a. ASPIRATION PNEUMONIA — 1 Hour
DUE TO (OR AS A CONSEQUENCE OF):

**Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST**
b. GLIOBASTOMA MULTIFORME
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**
TRACHEOSTOMY

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☒ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☒ YES 2 ☐ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: [signature] MD

**29c. LICENSE NUMBER**: D36095

**29d. DATE SIGNED** (Month, Day, Year) ▶ 4/9/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): KENT KESTON UNIV. HOSPITAL BALTIMORE, MD 21201

**31. DATE FILED** (Month, Day, Year): APR 12 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11067

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Harlee Jackson | | | 2. DATE OF DEATH (Month, Day, Year): 4-10-89 | 3. TIME OF DEATH: 11:45PM M |
| 4. SOCIAL SECURITY NUMBER: 217-12-9656 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 63 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 11-14-25 | 8. BIRTHPLACE (State or Foreign Country): Md |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4020 W. Rogers Avenue | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY? U S A |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): William G. Jackson | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Essie | | |
| 19a. INFORMANT'S NAME (Type/Print): Florence Jackson | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4020 N. Rogers Baltimore, Md 21215 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veteran Cemetery | 20c. LOCATION — City or Town, State: Owings Mills Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dale March | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hypertensive arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 X YES 2 ☐ NO | X YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Charles P. Kokes MD | OCME | ▶ 4-11-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn Street, Baltimore, MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 14 1989 | Davidson-Randall |

DHMH-16 Rev 1/89

89 11067

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11068
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Louis D. Jackson

**2. DATE OF DEATH** (Month, Day, Year): April 3 1989

**3. TIME OF DEATH**: 1040 A M

**4. SOCIAL SECURITY NUMBER**: 220-07-3527

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 69 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 4-27-19

**8. BIRTHPLACE** (State or Foreign Country): Md

**9a. FACILITY NAME** (If not institution, give street and number): University Hospital

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 [X] YES 2 [ ] NO

**10e. STREET AND NUMBER**: 514 N. Calhoun St

**10f. ZIP CODE**: 21223

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: Black

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5 +):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver

**16b. KIND OF BUSINESS/INDUSTRY**: Dignan Co.

**17. FATHER'S NAME** (First, Middle, Last): John Jackson

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Lillian

**19a. INFORMANT'S NAME** (Type/Print): Carole Atkins

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 Big Stone Ct Balto. Co. MD 21228

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Mt Auburn Cem

**20c. LOCATION — City or Town, State**: Baltimore, Md

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Dala March

**22. NAME AND ADDRESS OF FACILITY**: March F.H. West 4300 Wabash Ave

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Multiple Organ System Failure | 2d |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Upper Gastrointernal Bleeding | 7d |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Metastatic Adenocarcinoma of Liver, unknown primary unknown | |
| d. | | |

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**
Diabetes mellitus

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [X] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO N/A

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [X] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Daniel J Bank MD intern Dept. of Surgery

**29c. LICENSE NUMBER**:

**29d. DATE SIGNED** (Month, Day, Year) ▶

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Daniel J Bank MD Dept. of Surgery, Univ. of Md. Hospital, Baltimore MD

**31. DATE FILED** (Month, Day, Year): APR 08 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-18 Rev 1/89

XX XX

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11069 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Thomas Jackson | | | 2. DATE OF DEATH (Month, Day, Year): 4 14 89 | 3. TIME OF DEATH: 11:36 P M |
| 4. SOCIAL SECURITY NUMBER: 216-01-0210 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2/14/1904 | 8. BIRTHPLACE (State or Foreign Country) |
| 9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Maryland | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md. | | Baltimore | 1 [ ] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 2661 Lauretta Ave. | 21223 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 1 [ ] YES 2 [ ] NO Specify: | Specify: B |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| James Jackson | Susie Jackson |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILIND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Amy Jackson | 2661 Lauretta Ave. Baltimore, Md. 21223 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Mt. Auburn Cem. | Westport, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Cecil A Estep | Estep Bros. Funeral Home P.A. 1300 Eutaw Place |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | respiratory arrest | 5 min |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Cardiac arrest | 5 min |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Contractures
decubitus ulcers

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Washington MD | D 37618 | ▶ 4/14/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Jeane Washington Mercy Medical Center 301 St Paul Pl, Balt MD 21202

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 21 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11070
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): DELAPHINE (Delphine) E JAMES
**2. DATE OF DEATH** (Month, Day, Year): 4 8 89
**3. TIME OF DEATH**: 9.15 A M
**4. SOCIAL SECURITY NUMBER**: 212-03-1777
**5. SEX**: 1 ☐ M 2 ☒ F
**6. AGE** (In yrs. last birthday): 69 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
**7. DATE OF BIRTH** (Month, Day, Year): 12-1-19
**8. BIRTHPLACE** (State or Foreign Country): MD
**9a. FACILITY NAME** (If not institution, give street and number): BON SECOUR HOSPITAL
**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTIMORE CITY
**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD
**10b. COUNTY**:
**10c. CITY, TOWN OR LOCATION**: BALTIMORE CITY
**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO
**10e. STREET AND NUMBER**: 937 NORTH MOUNT STREET
**10f. ZIP CODE**: 21217
**10g. CITIZEN OF WHAT COUNTRY?**: USA
**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES: N/A
**13. WAS DECEDENT OF HISPANIC ORIGIN?** (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
**14. RACE — American Indian, Black, White, etc.** Specify: BLACK
**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+):
**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): LORING BYERS F.H.
**16b. KIND OF BUSINESS/INDUSTRY**: RETIRED
**17. FATHER'S NAME** (First, Middle, Last): JOHNNIE TIBBS
**18. MOTHER'S NAME** (First, Middle, Maiden Surname): ADA BURKE TIBBS
**19a. INFORMANT'S NAME** (Type/Print): MARVIN A. BURKE
**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 937 N. MOUNT STREET/BALTIMORE, MD. 21217
**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): BALTIMORE CEMETERY
**20c. LOCATION — City or Town, State**: BALTIMORE, MD
**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Julia R. March
**22. NAME AND ADDRESS OF FACILITY**: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE 21202

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CARDIOPULMONARY ARREST | |
| DUE TO (OR AS A CONSEQUENCE OF): b. | CONGESTIVE HEART FAILURE | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | VALVULAR HEART DISEASE | |
| d. | | |

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**: DIABETES MELLITUS; CHRONIC RENAL INSUFFICIENCY

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO
**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO
**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO
**26. PLACE OF DEATH** (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
**28a. DATE OF INJURY** (Month, Day, Year): N A
**28b. TIME OF INJURY**: N A M
**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO
**28d. DESCRIBE HOW INJURY OCCURED**:
**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify): N A
**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State): N A

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Surjit Julka
**29c. LICENSE NUMBER**: D 26395
**29d. DATE SIGNED** (Month, Day, Year): 4/8/89
**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): SURJIT JULKA M.D. 3455 WILKENS AVE BALTIMORE
**31. DATE FILED** (Month, Day, Year): APR 12 1989
**32. REGISTRAR'S SIGNATURE**: Davidson-Randall

DHMH-16 Rev 1/89

89 11071

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ALLEN HARLIN JOHANNES | | 2. DATE OF DEATH (Month / Day / Year): 4 / 3 / 1989 | 3. TIME OF DEATH: 12.35 M |
| 4. SOCIAL SECURITY NUMBER: 212-07-4353 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12/4/03 — 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: A.A. | 10c. CITY, TOWN OR LOCATION: Linthicum | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 10 Coronet Drive | | 10f. ZIP CODE: 21090 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th Grade — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Drive | 16b. KIND OF BUSINESS/INDUSTRY: National Biscut Co. | |
| 17. FATHER'S NAME (First, Middle, Last): Unknown Johannes | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Hilda Unknown | |
| 19a. INFORMANT'S NAME (Type/Print): JoAnn Moore | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 Coronet Drive Linthicum, Maryland 21090 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Doris E. Smith | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: (Unknown) Recent (R) leg amputation 2° ASVD

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] ND | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): N/A — 28b. TIME OF INJURY: N/A M — 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO N/A — 28d. DESCRIBE HOW INJURY OCCURED: N/A | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: C. Dickason MD | 29c. LICENSE NUMBER: D25935 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/3/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DICKASON, C. M.D. 3001 S HANOVER ST | | |
| 31. DATE FILED (Month, Day, Year): APR 5 1989 | 32. REGISTRAR'S SIGNATURE: Emmerson-Randall | |

DHMH-15 Rev 1/89

89 11071

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11072

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BERT LANE JOHNS | | | 2. DATE OF DEATH (Month/Day/Year): 04/ 13/ 89 | 3. TIME OF DEATH: 1:25 A M |
| 4. SOCIAL SECURITY NUMBER: 233-14-5455-A | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11-18-13 | 8. BIRTHPLACE (State or Foreign Country): Alabama |
| 9a. FACILITY NAME (If not institution, give street and number): JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: BALTIMORE CITY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3315 E. Balto. Street | 10f. ZIP CODE: 21224 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4 or 5+): ------ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist | 16b. KIND OF BUSINESS/INDUSTRY: Westinghouse | |
| 17. FATHER'S NAME (First, Middle, Last): Newton Johns | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Maudie Honeycutt | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Mattie Johns | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3315 E, Baltimore St. Balto. Md. 21224 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Md. Anne Arundel County | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph N. Zannino Jr. | 22. NAME AND ADDRESS OF FACILITY: Joseph N. Zannino Jr. Funeral Home 263 S. Conkling Street 21224 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Parkinson's Disease | 8 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Congestive Heart Failure. | 2 yrs. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Dementia | 5 yrs. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Myocardial Infarction | 3 days |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumoconiosis
Chronic Osteomyelohs

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Patrick L Mellen | 29c. LICENSE NUMBER: D37978 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/13/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Bruce Conklin MD Johns Hopkins Hospital Baltimore MD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): 4/13/89 APR 14 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11073
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LYNAL JONES | | | 2. DATE OF DEATH (Month, Day, Year): 4 2 89 | 3. TIME OF DEATH: 2:15 PM |
| 4. SOCIAL SECURITY NUMBER: 213079888 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 81 ~~XXX~~ YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 2-19-08 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Mason F. Lord Chronic Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | | Baltimore City | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 4605 Valley View Avenue | 21206 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☑ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 6 | | Steel Worker | Steel |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| James Jones | Adelia Blankenship |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Elizabeth M. Jones | 4605 Valley View Avenue Baltimore, Maryland 21206 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Green Mount Crematory 4/3/89 | Baltimore Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Michael J Ruck | Leonard J. Ruck, Inc. 5305 Harford Road 21214 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Bacteroides bacteremia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. decubitus ulcer | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia, CHF, CVA, Pacemaker

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☑ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) |
|---|---|
| 1 ☐ YES 2 ☑ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide S ☐ Pending Investigation S ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [illegible] Staff Physician | D28461 | ▶ 4/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Richard Bennett MD 5200 Eastern Ave Balto, MD 21224

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 4 1989 | Julia Davidson-Randall |

OHMH-18 Rev 1/89

89 11074

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GLADYS JOHNSON | | 2. DATE OF DEATH (Month, Day, Year): 04- 04- 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 248-72-5546 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 07-07-14 |
| 8. BIRTHPLACE (State or Foreign Country): SOUTH CAROLINA | | | |
| 9a. FACILITY NAME (If not institution, give street and number): BON SECOURS HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH: BALTIMORE CITY | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE CITY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2022 BOYD STREET | 10f. ZIP CODE: 21223 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RETIRED | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): BOSTON PRESSLEY | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LILLIE MOUZON | |
| 19a. INFORMANT'S NAME (Type/Print): QUEEN JACKSON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2573 WEST FAYETTE STREET (21223) | |
| 20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. AUBURN CEMETERY | 20c. LOCATION — City or Town, State: BALTO., MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lynette K. Jones | | 22. NAME AND ADDRESS OF FACILITY: BROWN-THOMPSON F.H. P.O. BOX 4433 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ~~Cardiovascular Accident~~ DSW Myocardial Infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Asthma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Debra Wertheimer MD | 29c. LICENSE NUMBER: D23767 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/5/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DEBRA WERTHEIMER, DO 861 PARK AVE, BALTO MD 21201 | | |
| 31. DATE FILED (Month, Day, Year): APR 07 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DNMN-16 Rev 1/89

89 11074

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11075

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be removed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 [illegible] attachment for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be n[illegible]**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): ROBERT G KERN
2. DATE OF DEATH (Month, Day, Year): 5 - 3 - 89
3. TIME OF DEATH: 12.01 AM/PM
4. SOCIAL SECURITY NUMBER: 169-14-6634
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 66 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-4-23
8. BIRTHPLACE (State or Foreign Country): PA.
9a. FACILITY NAME (If not institution, give street and number): HOMEWOOD HOSPITAL CENTER-SOUTH
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: —

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2632 N. CALVERT ST
10f. ZIP CODE: 21218
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: W
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PRIVATE DETECTIVE
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): FREDERICK KERN
18. MOTHER'S NAME (First, Middle, Maiden Surname): JENNY JOHNSON
19a. INFORMANT'S NAME (Type/Print): CHARLES ROBERT KERN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2814 N. CALVERT ST BALTO. MD. 21218
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): THE GREEN MOUNT CEMETERY
20c. LOCATION — City or Town, State: BALTO. MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edward J Weber
22. NAME AND ADDRESS OF FACILITY: JOHN M WEBER & SONS INC 401 S CHESTER ST.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. INTRACEREBRAL BLEEDING on 3/28/89 | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
- ASCV Heart Disease
- ATRIAL FIBRILLATION, CHRONIC CHF, IDDM LBBB

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY:
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURRED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Charbachul Woreta MD
29c. LICENSE NUMBER: D31905
29d. DATE SIGNED (Month, Day, Year): ▶ 5/3/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): AMBACHE WORETA HOMEWOOD (HOSPITAL (MEDICAL) CENTER BALTO MD
31. DATE FILED (Month, Day, Year): MAY 4 - 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 11075

Items 23a thu 28f Per M.E. FilmG652 6/2/89 CG

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11076 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Roslyn YVONNE Kutcherman
2. DATE OF DEATH (Month, Day, Year): 4 28 89
3. TIME OF DEATH: 9:33 P M
4. SOCIAL SECURITY NUMBER: 213-65-5919
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 35 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9-29-53
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Johns Hopkins Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1301 NORTH MILTON AVENUE
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): UNKNOWN — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNKNOWN
16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): JAMES CARTER
18. MOTHER'S NAME (First, Middle, Maiden Surname): HAZEL JONES
19a. INFORMANT'S NAME (Type/Print): HAZEL DRUMGULD
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 405 EAST 21st STREET/BALTIMORE, MD 21218
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): EASTVIEW MEMORIAL PK. CEMETERY
20c. LOCATION — City or Town, State: DUNDALK, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin L. Willis
22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute combined drug (cocaine and morphine) and alcohol

DUE TO (OR AS A CONSEQUENCE OF): intoxication

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☒ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): 4/28/89

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO

28d. DESCRIBE HOW INJURY OCCURED: Unknown

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Unknown

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Unknown

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin

29c. LICENSE NUMBER: OCME

29d. DATE SIGNED (Month, Day, Year): 4/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type or Print): Julia C. Goodin, M.D. , Assistant — 111 Penn St. Balto.MD.

31. DATE FILED (Month, Day, Year): MAY 4 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

89 11076

Items23a thu28f Per M.E. FilmG651 5/12/89CG

89 11077

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

2

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | | 3. TIME OF DEATH | | |
| Sophronia | Booker | Knox | 4-18-89 | | 11:37PM | M | |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) | |
| | 1 ☐ M 2 ☒ F | 40 YRS. | | | 12 7 48 | MARYLAND | |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 826 E. North Avenue | Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | | BALTIMORE | ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 826 EAST NORTH AVENUE | 21202 | US |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexicen, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | NURSES ASSISTANT | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| JOHN McCORMICK | HARRIETT STANTON |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| DEBRA HARRIS | 826 E. NORTH AVENUE BALTIMORE, MARYLAND 21202 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | MT. ZION CEMTERY | BALTIMORE, MARYLAND |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Dorotha Hecter #281 | E.L. PHILLIPS 1721 N. MONROE ST. 21217 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initisted events resulting in death) LAST | b. | |
| | OUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Cirrhosis hepatic steatosis

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Mario F. Golle Jr. M.D. | OCME | ▶ 4-19-89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) | |
|---|---|
| Mario F. Golle, Jr., M.D. | 111 Penn Street, Baltimore, MD 21201 VC |

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 24 1989 | Julia Nelson-Lindsay |

DHMN-18 Rev 1/89

89 11077

APR 2 4 1990

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11078
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Robert Gillis Kindred | | | 2. DATE OF DEATH (Month, Day, Year): 4 27 89 | 3. TIME OF DEATH: 0434 A M |
| 4. SOCIAL SECURITY NUMBER: 539-28-5834 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 64 YRS. (If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.) | 7. DATE OF BIRTH (Month, Day, Year): April 16, 1925 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): University of Maryland Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Rockville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO |
| 10e. STREET AND NUMBER: 11016 Rosemont Drive | 10f. ZIP CODE: 20852 | | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 7 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Physician | 16b. KIND OF BUSINESS/INDUSTRY: Medicine | |
| 17. FATHER'S NAME (First, Middle, Last): James E. Kindred | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Beatrice Gillis | | |
| 19a. INFORMANT'S NAME (Type/Print): Annabelle Adams Kindred | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11016 Rosemont Drive, Rockville, Maryland 20852 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. | 20c. LOCATION — City or Town, State: Bethesda, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Janice E. Perry M00803 | 22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ASEPSIS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Acute Myelogenous Leukemia | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary Aspergillosis
PANCYTOPENIA
ATRIAL Fibrillation

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 XX CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Howard Parnes | 29c. LICENSE NUMBER: D33472 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HOWARD PARNES, 22 S. Greene Street, Baltimore, Maryland

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): 4/27/89 APR 28 89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

20+1

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11079 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): PAUL ~~HERSHNER~~ Edwin Kesner

**2. DATE OF DEATH** MONTH 4 DAY 14 YEAR 89

**3. TIME OF DEATH**: 1:20 PM

**4. SOCIAL SECURITY NUMBER**: 220-32-2663

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 54 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 1 13 35

**8. BIRTHPLACE** (State or Foreign Country): Maryland

**9a. FACILITY NAME** (If not institution, give street and number): MERCY MEDICAL CENTER

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTIMORE, Md.

**9c. COUNTY OF DEATH**: BALTIMORE CITY

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md.

**10b. COUNTY**: Baltimore

**10c. CITY, TOWN OR LOCATION**: Middle River

**10d. INSIDE CITY LIMITS?** 1 [ ] YES 2 [X] NO

**10e. STREET AND NUMBER**: 7416 Greenbank Road

**10f. ZIP CODE**: 21220

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: Korean

**13. WAS DECEDENT OF HISPANIC ORIGIN?** (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 8+): 5+

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Civilian Auditor

**16b. KIND OF BUSINESS/INDUSTRY**: U.S.ARMY

**17. FATHER'S NAME** (First, Middle, Last): John Kesner

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Angelia Ford

**19a. INFORMANT'S NAME** (Type/Print): Joyce Victoria Kesner

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7416 Greenbank Road BAlto. Md. 21220

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Holly Hill Cemetery

**20c. LOCATION — City or Town, State**: MiddleRiver Md.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Connelly Funeral Home

**22. NAME AND ADDRESS OF FACILITY**: ConnellyFuneralHome 300MaceAve.21221

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ~~12TH CRANIAL~~ ASPIRATION PNEUMONIA — 5 DAYS

DUE TO (OR AS A CONSEQUENCE OF):

c. 12TH CRANIAL N. PALSY

DUE TO (OR AS A CONSEQUENCE OF):

d. METASTATIC SQUAMOUS CELL CARCINOMA OF THE LUNG — 5 MONTHS

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

HYPERCALCEMIA

HYPOKALEMIA

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [ ] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [ ] NO

**26. PLACE OF DEATH** (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending investigation 8 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Joseph C. Schwartz MD — ~~D.A.M. Feldman~~ D0930

**29c. LICENSE NUMBER**: ~~D 22 6 45~~

**29d. DATE SIGNED** (Month, Day, Year): ▶ 4/14/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): JOSEPH C. SCHWARTZ MD 1221 ST. PAUL PL BALT. MD. 21202

**31. DATE FILED** (Month, Day, Year): APR 20 1989

**32. REGISTRAR'S SIGNATURE**: Julia ...

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11080
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3, 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | | 3. TIME OF DEATH | |
| Thaddeus | | Kisielewski | 4-18-89 | | 6:01PM | M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
| 212-05-9919 | 1 ☑ M 2 ☐ F | 76 YRS. | | | 3-5-1913 | PA. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 1917 Bank Street | Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | | BAltimore City | 1 ☑ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1917 BANK Street | 21231 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☑ YES 2 ☐ NO — WWII | 1 ☐ YES 2 ☑ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | 2 | GROCER | SEIF-employed |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Bonislaw Kisielewski | Caroline Kuc |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Josephine Kawzan | 520 S. Broadway Balto. MD. 21231 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Holy Rosary Cemetery | Balto. MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ | John M. WEBER & Sons Inc 401 S. CHESTER St. Balto. MD. 21231 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |
| INQUIRY | |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Margarita Korell | OCME | ▶ 4-19-89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | |
|---|---|
| Margarita A. Korell, M.D. | 111 Penn Street, Baltimore, MD 21201 VC |

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 24 1989 | Julia Gordon-Landress |

DHMH-16 Rev 1/89

KOBYLSKI

89 11081

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Martha ~~Kobysi~~ Kobylski | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 10 89 | 3. TIME OF DEATH: 5:48 A M |
| 4. SOCIAL SECURITY NUMBER: N/A | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12/02/1901 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Church Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 38 S. Ellwood Ave. | | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Cauc. | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unk. College (1-4 or 5+): UNk. | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Domestic | | |
| 17. FATHER'S NAME (First, Middle, Last): Stanislaus Kozlowski | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Antonita Unknown | | |
| 19a. INFORMANT'S NAME (Type/Print): Helen Schultz | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3434 McShane Way Baltimore, Md. 21222 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Stanislaus Cem. | 20c. LOCATION — City or Town, State: Baltimore, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Bernard Dabrowski | 22. NAME AND ADDRESS OF FACILITY: B. Dabrowski & Son 2818 E. Baltimore St. Baltimore, Md. 21224 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one csuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ACUTE CARDIORESPIRATORY FAILURE | 1 DAY |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ARTERIOSCLEROTIC HEART DISEASE | + YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. SENILE DEMENTIA | + YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO |
|---|---|

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| B C Veneracion Jr | D13664 | ▶ April 19, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR B. C. VENERACION JR 3401 DUNDALK AVE BALTO MD 21222

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 24 1989 | Julia Bordon-Kendall |

DHMH-16 Rev 1/89

89 11081

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11082

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Stamatoula T. Koutsoutis | | 2. DATE OF DEATH (Month, Day, Year): 4 18 89 | 3. TIME OF DEATH: 2:25 P.M. |
| 4. SOCIAL SECURITY NUMBER: 217-09-1796 D | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 88 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Dec. 9, 1900 — 8. BIRTHPLACE (State or Foreign Country): Icaria, Greece |
| 9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: City | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2818 Rosalie Avenue | | 10f. ZIP CODE: 21234 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): John Tripoulas | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Angela Kassiotis | |
| 19a. INFORMANT'S NAME (Type/Print): Miss Angela Koutsoutis | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2818 Rosalie Avenue Baltimore, Md. 21234 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James J. Bladden | 22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck Inc. 5305 Harford Road 21214 | | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive Heart Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Chronic pericardial effusion. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation
Hypothyroidism
Hypertension

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| | NA | |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): NA | 28b. TIME OF INJURY: NA M | 28c. INJURY AT WORK? NA 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED: NA |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): NA | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): NA |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Anthony W. Macasieb DO | 29c. LICENSE NUMBER: | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/18/89. |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4412 Falls Brdge Dr. Apt H. Bull. md 21211 | | |
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11083
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| George | J. | Kubin | April 23, 1989 | 12:55A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-18-3498 | 1 [X] M 2 [ ] F | 65 YRS. | | | FEB.28 1924 | MD. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Maryland General Hospital | Baltimore City | ----- |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md. | Baltimore | Baltimore | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 9419 Perry Hall Boulevard | 21236 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| n/a | n/a | Laborer | Continental Co. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Josef Kubin | Josefa Zunt |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Emilie Sychuk (sister) | 9419 Perry Hall Boulevard, Balto. Md. 21236 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Bohemian National | Baltimore Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Dennis A Capitano | SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Balto, Md. 21213 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hemorrhage into the urinary bladder and prostate gland | |
| | DUE TO (OR AS A CONSEQUENCE OF): Acquired bleeding disorder | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): by history, Brain stem infarct. | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [X] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| James L. Cole MD | n/a | ▶ 4/24/89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | |
|---|---|
| James J. Cole, M.D. | c/o Maryland General Hosptial |

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 25 1989 | Julia Davidson-Landers |

DHMH-16 Rev 1/89

88 11083

89 11084

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): CARRIE KULIK

**2. DATE OF DEATH** (Month, Day, Year): 04 / 21 / 89

**3. TIME OF DEATH**: 10 30P M

**4. SOCIAL SECURITY NUMBER**:

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 92 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 2-6-1897

**8. BIRTHPLACE** (State or Foreign Country): POLAND

**9a. FACILITY NAME** (If not institution, give street and number): GOODSAMARITAN HOSP

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTIMORE

**9c. COUNTY OF DEATH**: BALTIMORE

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: BALTIMORE

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 1923 GOUGH Street

**10f. ZIP CODE**: 21231

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 6th
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): JACOB ZASOWSKI

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): MARY UNKNOWN

**19a. INFORMANT'S NAME** (Type/Print): FRANK KULIK

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8105 Calla LANE BALTO. MD 21237

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Holy Rosary Cemetery

**20c. LOCATION — City or Town, State**: BALTO. MD

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Edward J Weber

**22. NAME AND ADDRESS OF FACILITY**: John M. WEBER & Sons Inc 401 S. Chester St. 21231

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Respiratory / Cardiac Arrest

DUE TO (OR AS A CONSEQUENCE OF):
b. Metabolic Encephalopathy / Bowel Failure

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. Small Bowel Obstruction

DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Telephone Intern

**29c. LICENSE NUMBER**: D 38118

**29d. DATE SIGNED** (Month, Day, Year) ▶

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): XENOPOULIS NICHOLAS 5801 Loch Raven Blvd Balt. MD 21239

**31. DATE FILED** (Month, Day, Year): 04/21/89

**32. REGISTRAR'S SIGNATURE**: APR 24 1989 Julia Davidson-Kendall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11085

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Linda | Charmaine | Kirby | Apr 28-89 | 7:05AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220.66.1075 | 1 ☐ M 2 ☒ F | 41 YRS. | | | Aug. 20, 1947 | Ohio |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 426 Hornel Street | Baltimore City | Baltimore City |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Baltimore City | Baltimore City | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 426 Hornel Street | 21224 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 6 | None | Homemaker | Own Home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Gordon L. Marksberry | Virginia Unknown |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Charles T. Kirby | 426 Hornel St., Baltimore, Md. 21224 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Security Process, Inc. | Catonsville, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ R. Hooya Hakim | #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. 21061 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Thermal injury and smoke inhalation

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| ☒ YES 2 ☐ NO | ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☒ Could not be determined | 4-28-89 | M | 1 ☐ YES 2 ☒ NO | victim burned -house fire |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| home | 426 Hornell Avenue |

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin | OCME | ▶ 4-28-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print)

Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201 vc

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 4 - 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11086
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Margaret E. Kinder (Margaret Kinder)

**2. DATE OF DEATH** Month: April Day: 30 Year: 89

**3. TIME OF DEATH**: 4:25 A M

**4. SOCIAL SECURITY NUMBER**: 216-07-2894

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 79 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): Nov. 10, 1909

**8. BIRTHPLACE** (State or Foreign Country): Md.

**9a. FACILITY NAME** (If not institution, give street and number): Francis Scott Key Med. Center

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore

**9c. COUNTY OF DEATH**: --

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md.

**10b. COUNTY**: --

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 4220 Parkside Drive

**10f. ZIP CODE**: 21206

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): N/A
College (1-4 or 5+): N/A

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): homemaker

**16b. KIND OF BUSINESS/INDUSTRY**: own home

**17. FATHER'S NAME** (First, Middle, Last): Albert A. Walper

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Anna Margaret Behringer

**19a. INFORMANT'S NAME** (Type/Print): Ronald A. Walper - Cousin

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4511 Harcourt Rd, Baltimore, Maryland 21214

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Oaklawn Cemetery

**20c. LOCATION — City or Town, State**: Baltimore, Md.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Eugene J. Lautman Jr

**22. NAME AND ADDRESS OF FACILITY**: SCHIMUNEK FUNERAL HOME, INC.
3331 Brehms Lane, Balto. Md. 21213

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | hypoxia | |
| DUE TO (OR AS A CONSEQUENCE OF): b. | pneumonia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| d. | | |

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Sepsis, tardive dyskinesia

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☒ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: ✓ M. R. Blackman MD.

**29c. LICENSE NUMBER**: ✓ D181446

**29d. DATE SIGNED** (Month, Day, Year): ✓

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): M. CHISOLM, MD FSKMC

**31. DATE FILED** (Month, Day, Year): MAY 4 1989

**32. REGISTRAR'S SIGNATURE**: Julia Tarleton Rhodes

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11087 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 5 should be detached for use as the burial permit.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EUGENE KING | | 2. DATE OF DEATH (Month, Day, Year): APRIL 29, 1989 | 3. TIME OF DEATH: 8:40 P M |
| 4. SOCIAL SECURITY NUMBER: 531-26-4717 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 61 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 3/15/28 |
| 8. BIRTHPLACE (State or Foreign Country): Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: BALTIMORE | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 422 North Clinton Street | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 8+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): carpenter | 16b. KIND OF BUSINESS/INDUSTRY: self-employed | |
| 17. FATHER'S NAME (First, Middle, Last): William Jona King | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Clark | | |
| 19a. INFORMANT'S NAME (Type/Print): Alic B. King | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3116 Gamber Road/Finksburg MD 21048 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest | 20c. LOCATION — City or Town, State: Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Roland P. Staub Jr | 22. NAME AND ADDRESS OF FACILITY: John A. Moran Funeral Home 3000 E. Baltimore St. Balto. MD 21224 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis | 6 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Whipple's Disease | 1 year |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| E. Daoud MD | | 4/29/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E. DAOUD 600 N. WOLFE ST. JOHNS HOPKINS H. BALTI. MD. 21205

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 2 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

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MAY 2

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11088
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Bertha Knach | | | | | 2. DATE OF DEATH: MONTH 04 DAY 22 YEAR 89 | 3. TIME OF DEATH: 1:52 P M | |
| 4. SOCIAL SECURITY NUMBER: 214-03-2715 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8/29/04 | 8. BIRTHPLACE (State or Foreign Country): MD | |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center Eastern Ave | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: United States | | |
| **RESIDENCE OF DECEDENT** | | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Balto | 10c. CITY, TOWN OR LOCATION: Baltimore City | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | | |
| 10e. STREET AND NUMBER: 1300 SOUTH Ellwood Ave | | 10f. ZIP CODE: 21224 | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5th grade; College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Seamstress | | | 16b. KIND OF BUSINESS/INDUSTRY | | |
| 17. FATHER'S NAME (First, Middle, Last): IGNATIUS KNACH | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARYANNA GORAJEWSKI | | |
| 19a. INFORMANT'S NAME (Type/Print): LORRAINE GIERCZAK | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 606 S. POTOMAC ST. 21224 | | | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. STANISLAUS CEMETERY | | | 20c. LOCATION — City or Town, State: BALTIMORE MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Raymond L. Kacprowski | | 22. NAME AND ADDRESS OF FACILITY: 2525 FLEET STREET | | | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Ischemic Heart Disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |
|---|---|

| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | D32807 | ▶ 4/25/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stacey Sleeth MD 4940 Eastern Avenue

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 26 1989 | Julie Dickerson-Lukasik |

OHMH-16 Rev 1/89

88011 08

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11089

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES S. KRASKI JR.
2. DATE OF DEATH (Month, Day, Year): APRIL 23, 1989
3. TIME OF DEATH: 4:30 A M
4. SOCIAL SECURITY NUMBER: 217-76-8701
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 46 YRS. (If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.)
7. DATE OF BIRTH (Month, Day, Year): AUG. 28, 1942
8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3102 FOSTER AVE.
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): NONE; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DISABLED
16b. KIND OF BUSINESS/INDUSTRY: —
17. FATHER'S NAME (First, Middle, Last): JAMES S. KRASKI SR.
18. MOTHER'S NAME (First, Middle, Maiden Surname): FRANCES GOSCINSKI
19a. INFORMANT'S NAME (Type/Print): FRANCES KRASKI
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3102 FOSTER AVE. BALTO., MD. 21224
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SAC. HEART OF JESUS
20c. LOCATION — City or Town, State: BALTO. CO. MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Thomas J. Skarda Jr.
22. NAME AND ADDRESS OF FACILITY: THOMAS J. SKARDA 2829 HUDSON ST

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiopulmonary Arrest — 5-10 min
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
cerebral Palsy / mental retardation
Aspiration Pneumonia.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Steven J. O'Day
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 4/23/89.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Steven J. O'Day MD. Johns Hopkins Hospital.
31. DATE FILED (Month, Day, Year): APR 26 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

89 11090

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician; TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EDGAR T. KING, JR. | | | 2. DATE OF DEATH (Month, Day, Year): 04 25 89 | 3. TIME OF DEATH: 0931 A M |
| 4. SOCIAL SECURITY NUMBER: 213-72-6527 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 30 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 05/05/58 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Baltimore City | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 4016 ROSECREST AVE. | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 8+): 4 YRS. | 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MAINTANCE MECHANIC | 16b. KIND OF BUSINESS/INDUSTRY: MORGAN ST. UNIV. |
| 17. FATHER'S NAME (First, Middle, Last): EDGAR KING, SR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): EARLINE KING | |
| 19a. INFORMANT'S NAME (Type/Print): MR. & MRS EDGAR & EARLINE KING | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4016 ROSECREST AVE. BALTO, MD. 21215 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CREST LAWN CEMETERY | 20c. LOCATION — City or Town, State: HOWARD CO., MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary L. Rollins | | 22. NAME AND ADDRESS OF FACILITY: NUTTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY, BALTO, MD. 21216 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Bradicardia → Sinus arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Severe acidosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. END STAGE RENAL DISEASE | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: ZYI SELA MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4-25-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR ZYI SELA SINAI HOSPITAL Belvedere at Greenspring

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR-28-1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

1+1

Item #4 corrected per F.H 5-1-89 reb

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11091 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William R, Keston
2. DATE OF DEATH (Month, Day, Year): April 7, 1989
3. TIME OF DEATH: 11:30A M
4. SOCIAL SECURITY NUMBER: ~~214-16-8155~~ 216-14-8155
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 65 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 11-13-23
8. BIRTHPLACE (State or Foreign Country): Balto Md
9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 2943 Belmont Ave
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY? U.S.A
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: W.W.II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RETIRED
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Samuel Keston
18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Clatterbuck
19a. INFORMANT'S NAME (Type/Print): Delores Keston
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2943 Belmont Ave Balto Md 21216
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest V.A
20c. LOCATION — City or Town, State: Balto Co Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph L. Russ
22. NAME AND ADDRESS OF FACILITY: 2222 W. North Ave Balto Md 21216

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Oat Cell Carcinoma of the lung | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Gastro-intestinal bleeding; Pneumonia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 5 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 5 ☐ Could not be determined
25a. DATE OF INJURY (Month, Day, Year):
25b. TIME OF INJURY: M
25c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
25d. DESCRIBE HOW INJURY OCCURED:
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ian Tang MD
29c. LICENSE NUMBER: n/a/
29d. DATE SIGNED (Month, Day, Year): ▶ 4/7/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ian Tang, M.D. c/o Maryland General Hospital
31. DATE FILED (Month, Day, Year): APR 11 1989
32. REGISTRAR'S SIGNATURE: [illegible] Randall

DHMH-15 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11092
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOHN A KENDRICK | | | 2. DATE OF DEATH (Month, Day, Year): 4 28 89 | 3. TIME OF DEATH: 3:03P M |
| 4. SOCIAL SECURITY NUMBER: 238 12 7553-A | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8-5-16 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND S.C |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 501 W. FRANKLIN ST. | | 10f. ZIP CODE: 21201 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5 / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER | 16b. KIND OF BUSINESS/INDUSTRY: ASPHALT | |
| 17. FATHER'S NAME (First, Middle, Last): ROBERT KENDRICK | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MATTIE | |
| 19a. INFORMANT'S NAME (Type/Print): WILLIE BOLTON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2435 W LAFAYETTE AVE BALTO MD 21216 | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARLINGTON MEM. PK | 20c. LOCATION — City or Town, State: BALTO MD 21227 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Marshall H Hayes | | 22. NAME AND ADDRESS OF FACILITY: MARSHALL P. HAYES FUNERAL HOME 638 W. Gilmore Street | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Recurrent Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CVA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. CHF | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Bernard Neufeld | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4-28-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11093
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Paul William Kramp Sr. | | | | 2. DATE OF DEATH (Month, Day, Year): 4 / 3 / 89 | 3. TIME OF DEATH: 1:24 P M |
| 4. SOCIAL SECURITY NUMBER: 213-34-2346 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 51 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): June 8, 1937 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Balto. City |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Riviera Beach | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 8473 Sexton Drive | | 10f. ZIP CODE: 21122 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Steel Worker | 16b. KIND OF BUSINESS/INDUSTRY: Beth Steel |
| 17. FATHER'S NAME (First, Middle, Last): Peter John Kramp | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Schady |
| 19a. INFORMANT'S NAME (Type/Print): Sieglinde A. Kramp | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8473 Sexton Drive Riviera Beach, Md. 21122 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Brooklyn, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard C Doris | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home | 4001 Ritchie Hwy. Baltimore, Md. 21225 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Atherosclerotic Cardiovascular Disease | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Myocardial Failure | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Em Physema (Severe)

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Lawrence P. Sherman MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4-13-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Lawrence P. Sherman, MD Harbor Hospital Center

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 18 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall |

DHMH-16 Rev 1/89

89 11094

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Martha M. Kulczycka | | | | | 2. DATE OF DEATH Month: 4 Day: 28 Year: 89 | 3. TIME OF DEATH: 10:45 A.M |
| 4. SOCIAL SECURITY NUMBER: 218 32 3630 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 89 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): January 28 00 | 8. BIRTHPLACE (State or Foreign Country): Austria |
| 9a. FACILITY NAME (If not institution, give street and number): Caton Manor Nursing Home | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: === | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: +++ | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3717 Second St. | | 10f. ZIP CODE: 21225 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3 / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self - Employed | 16b. KIND OF BUSINESS/INDUSTRY: Seaford |
| 17. FATHER'S NAME (First, Middle, Last): John Hapij | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary ======== | |
| 19a. INFORMANT'S NAME (Type/Print): Olga Irvin Vine | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3717 Second Street Baltimore, Maryland 21225 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Cross Cemeterry | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jerome Framiowski | | 22. NAME AND ADDRESS OF FACILITY: George J. Gonce Funeral Home 4001 Ritchie Highway Balto Md 212225 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory arrest DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. CVA + Ureterostomy DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Hypertension + ASCVD | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| William M Carr MD | D-17821 | ▶ 4/28/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 11065 Little Patuxent Parkway Columbia, MD 21044

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 1 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

82 11034

89 11095

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUTH M. KANKOSKY
2. DATE OF DEATH (Month, Day, Year): 4 24 89
3. TIME OF DEATH: 6 15 P M
4. SOCIAL SECURITY NUMBER: 213-22-4104
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11/04/1905
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Howard
10c. CITY, TOWN OR LOCATION: Ellicott City
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 2944 Rogers Ave.
10f. ZIP CODE: 21043
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dietician
16b. KIND OF BUSINESS/INDUSTRY: Mt. Wilson State Hospital
17. FATHER'S NAME (First, Middle, Last): John H Twigg
18. MOTHER'S NAME (First, Middle, Maiden Surname): Doris E Goldsborough
19a. INFORMANT'S NAME (Type/Print): Diana McCullough
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2944 Rogers Ave., Ellicott City Md 21043
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery
20c. LOCATION — City or Town, State: Pikesville Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry H. Witzke
22. NAME AND ADDRESS OF FACILITY: 4112 Old Columbia Pike — Harry H Witzke Funeral HMme Inc Ellicott City

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Previous STROK
Rheumatoid arthritis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
25. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Raafat Y. Girgis
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 4/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Raafat Y. Girgis 500 N. Rolling Rd. Catonsville MD
31. DATE FILED (Month, Day, Year): APR 25 89
32. REGISTRAR'S SIGNATURE: Jackie Davidson-Randall

DHMH-18 Rev 1/89

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89 11096

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be detached for use as the burial permit.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOROTHY E. KASPER
2. DATE OF DEATH: MONTH 4 DAY 23 YEAR 89
3. TIME OF DEATH: 1:40 P M
4. SOCIAL SECURITY NUMBER: 216-07-2910
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 69 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 08/06/19
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: City

**RESIDENCE OF DECEDENT**

10a. STATE: Maryland
10b. COUNTY: City
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4800 Yellowwood Ave.
10f. ZIP CODE: 21209
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade | College (1-4 or 5+): ---
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clothing Estimator
16b. KIND OF BUSINESS/INDUSTRY: Genesco
17. FATHER'S NAME (First, Middle, Last): Anthony Nieberding
18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Luckert
19a. INFORMANT'S NAME (Type/Print): Mrs. Mary Ellen Anton
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2199 Pennsbury Dr. Jamison, PA 18929
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Carroll Cremation Service
20c. LOCATION — City or Town, State: Hampstead, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John K Aumiller Jr
22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Heart Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: aorto - Femoral bypass Bilateral

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 5 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: R. E. Lee, M.D
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): ▶ 4/23/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Good Samaritan Hospital
31. DATE FILED (Month, Day, Year): APR 28 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-15 Rev 1/89

89 11097

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Walter S. Kane

2. DATE OF DEATH — MONTH: 4 DAY: 8 YEAR: 89

3. TIME OF DEATH: 0225 M

4. SOCIAL SECURITY NUMBER: 204-32-1131

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 85 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 5-30-03

8. BIRTHPLACE (State or Foreign Country): Pennsylvania

9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Catonsville

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 601 Maiden Choice Lane

10f. ZIP CODE: 21228

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): UNAVAILABLE
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Finisher

16b. KIND OF BUSINESS/INDUSTRY: Shoe Manufacturing

17. FATHER'S NAME (First, Middle, Last): Joseph Kane

18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Dzlmalska

19a. INFORMANT'S NAME (Type/Print): Sr. Maureen

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 601 Maiden Choice Lane Baltimore, MD 21228

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery

20c. LOCATION — City or Town, State: Baltimore, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul P. Smith

22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc.
4107 Wilkens Ave. Baltimore, MD 21229

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael K. Ro MD House office

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year): ▶ 4/8/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael K. Ro, M.D. St. Agnes Hospital

31. DATE FILED (Month, Day, Year): APR 10 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11098

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Catherine F. Kazimer | | 2. DATE OF DEATH (Month, Day, Year): 4-7-1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 213-28-7788 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 58 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 3-11-1931 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 508 N. Luzerne Ave. | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: ---- | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Md. | 10b. COUNTY: ---- | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 508 N. Luzerne Ave. | 10f. ZIP CODE: 21205 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 8+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cashier | 16b. KIND OF BUSINESS/INDUSTRY: Store | |
| 17. FATHER'S NAME (First, Middle, Last): Clarence Jordan, Sr. | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Evelyn B. Getner | | |
| 19a. INFORMANT'S NAME (Type/Print): John J. Kazimer, Jr. | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 508 N. Luzerne Ave. Balto., Md. 21205 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GreenMount Crematory | 20c. LOCATION — City or Town, State: Balto., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Hartley Miller | 22. NAME AND ADDRESS OF FACILITY: Hartley Miller Funeral Home 7527 Harford Rd. Balto., Md. 21234 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Myocardial Infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Coronary Artery Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Congestive HT Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD
Asthma.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| M To—t, MD. | D 3245 | ▶ 4/7/89. |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Suite 34, Church Hospital Dundalk Center 1576 Merritt Blvd 21222 — Suite (34)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 10 1989 | Gina Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

'89 11099 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARY EUGENIA KELLY | | | 2. DATE OF DEATH: MONTH 4 DAY 10 YEAR 89 | 3. TIME OF DEATH: 6:50 A M |
| 4. SOCIAL SECURITY NUMBER: 217-09-3569 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10-6-05 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Keswick | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Towson | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 324 StevensoN Lane | | 10f. ZIP CODE: 21204 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 Years; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Assistant Manager | 16b. KIND OF BUSINESS/INDUSTRY: Apartment Bldg. | |
| 17. FATHER'S NAME (First, Middle, Last): John J. Kelly, Jr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Smith | |
| 19a. INFORMANT'S NAME (Type/Print): Elizabeth Kelly Heuisler | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 Overidge Ct. Baltimore, Md. 21210 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery | 20c. LOCATION — City or Town, State: Baltimore. Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F. Bannick, Jr. | | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic heart disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. with congestive failure | 1 year |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus, Type I, with Nephropathy, retinopathy, neuropathy

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M B Heuisler Jr MD | 29c. LICENSE NUMBER: D02225 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/10/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Keswick 700 W. 40th St, Baltimore 21211 | | |
| 31. DATE FILED (Month, Day, Year): APR 11 1989 | 32. REGISTRAR'S SIGNATURE: Jicha Davidson Hughes | |

DNMN-15 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11100
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): THOMAS PATRICK KELLY, JR.

**2. DATE OF DEATH** — MONTH: 4 DAY: 5 YEAR: 89

**3. TIME OF DEATH**: 7:35 P M

**4. SOCIAL SECURITY NUMBER**: 212079499

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 70 YRS.

IF UNDER 1 YEAR — MONTHS / DAYS; IF UNDER 24 HRS. — HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 9-4-18

**8. BIRTHPLACE** (State or Foreign Country): Balto-

**9a. FACILITY NAME** (If not institution, give street and number): MERCY MEDICAL CENTER

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTO. MD.

**9c. COUNTY OF DEATH**: --

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md.

**10b. COUNTY**: --

**10c. CITY, TOWN OR LOCATION**: Baltimore,

**10d. INSIDE CITY LIMITS?** 1 [X] YES 2 [ ] NO

**10e. STREET AND NUMBER**: 3009 Pelham Avenue

**10f. ZIP CODE**: 21213

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** [XX] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th Grade
College (1-4 or 5+): --

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Accountant

**16b. KIND OF BUSINESS/INDUSTRY**: Moving & Storage

**17. FATHER'S NAME** (First, Middle, Last): Thomas Patrick Kelley, Sr.

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Mary M. Weiss

**19a. INFORMANT'S NAME** (Type/Print): Beverly L. Kelly - wife

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3009 Pelham Avenue, Balto, Md. 21213

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Parkwood Cemetery

**20c. LOCATION — City or Town, State**: Balto, Md.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Eugene J. Lastner Jr

**22. NAME AND ADDRESS OF FACILITY**: SCHIMUNEK FUNERAL HOME
3331 Brehms Lane, Balto, Md. 21213

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic colon carcinoma — 2 yrs.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. _____ DUE TO (OR AS A CONSEQUENCE OF):
c. _____ DUE TO (OR AS A CONSEQUENCE OF):
d. _____

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**
pneumonia
renal failure
Bx Leukemia

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [ ] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [ ] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Thom J. McQuown

**29c. LICENSE NUMBER**: D07390

**29d. DATE SIGNED** (Month, Day, Year): ▶ 4-5-89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): MERCY MEDICAL CENTER 301 St. Paul Place 21202

**31. DATE FILED** (Month, Day, Year): APR 07 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

OHMN-16 Rev 1/89

89 11101

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. ... 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Bobby G Kirkland | | | 2. DATE OF DEATH (Month, Day, Year): April 12 1989 | 3. TIME OF DEATH: 5:42 A M |
| 4. SOCIAL SECURITY NUMBER: 226-42-8222 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): March 28, 1938 | 8. BIRTHPLACE (State or Foreign Country): North Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): University Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md. | | 9c. COUNTY OF DEATH: none |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: none | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 416 N. Hilton Street | 10f. ZIP CODE: 21229 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: After 1955 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Janitor | 16b. KIND OF BUSINESS/INDUSTRY: Cleaning |
| 17. FATHER'S NAME (First, Middle, Last): J. D. Kirkland | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Gaston | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Frances Kirkland | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 416 N. Hilton Balto., Md. 21229 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crownsville V.A. | 20c. LOCATION — City or Town, State: Crownsville, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James A. Morton & Sons | | 22. NAME AND ADDRESS OF FACILITY: Baltimore, Md. 21217 Morton & Sons 1701-31 Laurens St. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Spinal Cord Compression | 36 hours |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Metastatic Squamous Cell Carcinoma of Oropharynx | 1 month |
| DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Michael J. Damiano MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/12/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael J. Damiano MD University Hospital 22 S. Greene St. Baltimore, Md 21201 | | |
| 31. DATE FILED (Month, Day, Year): APR 13 1989 | 32. REGISTRAR'S SIGNATURE | |

DHMH-18 Rev 1/89

89 11101

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11102
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Chester C King
2. DATE OF DEATH: Month: April Day: 9 Year: 1989
3. TIME OF DEATH: 1:35 PM
4. SOCIAL SECURITY NUMBER: 220-09-3539
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 73 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 09/21/15
8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: --
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 831 West 38th Street
10f. ZIP CODE: 21211
10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Painter
16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): David King
16. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Bortel

19a. INFORMANT'S NAME (Type/Print): Edna V. King
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 831 West 38th Street, Balto., Md. 21211

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Poplar Grove Methodist Ch.
20c. LOCATION — City or Town, State: Cockeysville, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ A. Alan Seitz, Jr.
22. NAME AND ADDRESS OF FACILITY: A. Alan Seitz, Jr. Funeral Home, 3818 Roland Ave., Baltimore, Md. 21211

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Acute Anterolateral Myocardial Infraction | 7 days |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Coronary Arteriosclerosis | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Richard R Graham, MD
29c. LICENSE NUMBER: D15883
29d. DATE SIGNED (Month, Day, Year) ▶ April 9 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard R. Graham, MD Union Memorial Hospital 201 East University Pkwy

31. DATE FILED (Month, Day, Year): April APR 11 1989
32. REGISTRAR'S SIGNATURE: Richard R Graham, MD

DHMN-18 Rev 1/89

SOIII 88

89 11103

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): David Christian Kratzer
2. DATE OF DEATH (Month, Day, Year): April 7, 1989
3. TIME OF DEATH: 10 X M
4. SOCIAL SECURITY NUMBER: 215.05.0369
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 76 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): March 29, 1913
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: NA

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: North Linthicum
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 25 Mansion Road
10f. ZIP CODE: 21090
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Stock Broker
16b. KIND OF BUSINESS/INDUSTRY: Investment (RET)
17. FATHER'S NAME (First, Middle, Last): (Unknown) Kratzer
18. MOTHER'S NAME (First, Middle, Maiden Surname): (Unknown)
19a. INFORMANT'S NAME (Type/Print): Mark C. Kratzer
19b. MAILIND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Singleton Funeral Home, #1 Second Avenue S.W., Glen Burnie, Maryland 21061

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiopulmonary Arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): | Hypertension | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): NA
28b. TIME OF INJURY: NA M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: NA
26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): NA
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State): NA

29a. CERTIFIER (Check only one)
1 [X] CERTIFYIND PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 4/7/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. Grant 3001 S. Hanover St Baltimore, Md 21230
31. DATE FILED (Month, Day, Year): APR 11 1989
32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11104
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| AGNES | KOWALSKI | (MACK) | 04-6-89 | M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-09-4499 | 1 ☐ M 2 ☒ F | 83 YRS. | | | 1-21-06 | MARYLAND |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 629 S. KENWOOD AVE. 21224 | BALTIMORE | CITY |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | | BALTIMORE CITY | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 629 S. KENWOOD AVE. | 21224 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 6 YEARS | | HOMEMAKER | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| BARTHOLOMEW LISEK | MAGDALENA KOSCIELNA |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MRS. JOAN SAIERSKI | 629 S. KENWOOD AVE. BALTO. MD. 21224 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | SACRED HEART OF JESUS CEM. | BALTO. CO. MD. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Raymond L. Kaczorowski | KACZOROWSKI FUNERAL HOME<br>2525 FLEET ST. BALTO. MD. 21224 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Cardiopulmonary Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension Non Insulin Dep Diabetes Mellitus Obesity

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Home |

| 27. MANNER OF DEATH | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY | 26c. INJURY AT WORK? | 26d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Theodore Wznik MD | D0[illegible]517 | ▶ 4-7-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

T. T. WIZNIK MD - 429 S Chester St 21231

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| 4-7-89 | APR 10 1989 Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 11104

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11105
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Marie H. Krebs | | | 2. DATE OF DEATH (Month, Day, Year): April 19, 1989 | 3. TIME OF DEATH: 11:45 P M |
| 4. SOCIAL SECURITY NUMBER: 212-50-5307 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 91 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 1-7-1898 | 8. BIRTHPLACE (State or Foreign Country): Balto. Co. |
| 9a. FACILITY NAME (If not institution, give street and number): 2111 BElair Road | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Maryland | | 9c. COUNTY OF DEATH: Baltimore, City |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2111 Belair Road | | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): John Schwarz | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Souder | |
| 19a. INFORMANT'S NAME (Type/Print): Frank W. Krebs Jr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2111 Belair Road-21206 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: John c. Miller, Inc. | 6415 BElair Road Balto. Md.-21206 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CVA | 4 Hrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. | ASCVD c previous CVA | 4yrs |
| DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Seppetedsion

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D09804 | 29d. DATE SIGNED (Month, Day, Year): 4-20-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RICHARD R RIGLER MD. 4915 HOLDER AVE 21214 | | |
| 31. DATE FILED (Month, Day, Year): APR 21 1989 | 32. REGISTRAR'S SIGNATURE: [signature] | |

OHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

M

10

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Minnie Kress | | | 2. DATE OF DEATH (Month, Day, Year): 04 03 89 | 3. TIME OF DEATH: 1030 P M |
| 4. SOCIAL SECURITY NUMBER: 219-52-2586 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 62 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5/14/26 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Med Cntr | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City, Md | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 134 SOUTH EAST AVE | | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): Hiram George Richardson | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Maude S. Creagh | |
| 19a. INFORMANT'S NAME (Type/Print): Stephen T. Kress | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 134 South East Ave./Balto. MD 21224 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn | 20c. LOCATION — City or Town, State: Balto., MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Peter D. Moran | 22. NAME AND ADDRESS OF FACILITY: John A. Moran Funeral Home 3000 E. Baltimore St/21224 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Ischemic heart disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: R E Freeman MD | 29c. LICENSE NUMBER: D37065 | 29d. DATE SIGNED (Month, Day, Year): ▶ April 3, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RICHARD FREEMAN MD 4940 EASTERN AVE BALTo MD 21224

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 5 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 11105

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 must be completed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Attached for use as the burial-transit permit. Pages 1, 2, 3 should be completed by the funeral director.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DOROTHY E. LIEDTKE | | 2. DATE OF DEATH (Month, Day, Year): May 4, 1989 | 3. TIME OF DEATH: 2:20 PM |
| 4. SOCIAL SECURITY NUMBER: 215-05-2451 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 80 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): Dec 3, 1908 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Meridian, Homewood | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: ---------- | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: ---------- | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3015 O'Donnell Street | 10f. ZIP CODE: 21205 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: ☒ 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 Years; College (1-4 or 8+): ---------- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales | 16b. KIND OF BUSINESS/INDUSTRY: Jewlery | |
| 17. FATHER'S NAME (First, Middle, Last): Otto Liedtke | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Shor | | |
| 19a. INFORMANT'S NAME (Type/Print): John Aumiller | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5920 Donache Rd. Apt.1009 Baltimore, MD 21239 | | |
| 20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oaklawn Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William E. Johnson | 22. NAME AND ADDRESS OF FACILITY: William E. Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21204 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Advanced senile Dementia
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
- Dehydration
- Chronic Renal failure.
- UTI Urinary Track infection.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D-17992 | 29d. DATE SIGNED (Month, Day, Year): 5/5/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1006 Taylor Avenue Towson Md 21204 | | |
| 31. DATE FILED (Month, Day, Year): MAY 5 1989 | 32. REGISTRAR'S SIGNATURE: Gene Davidson-Randall | |

DHMH-16 Rev 1/89

89 11108

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... after death. Page 6 may be retained by the physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed ... by the funeral director, page 5 should be de... burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at on...**

### TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helen Leach
2. DATE OF DEATH: MONTH 5 DAY 2 YEAR 89
3. TIME OF DEATH: 10:08 P.M.
4. SOCIAL SECURITY NUMBER: 214-16-5781
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-18-18
8. BIRTHPLACE (State or Foreign Country): Va
9a. FACILITY NAME (If not institution, give street and number): Homewood South Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2522 N. Ellamont St
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Andrew Washington
18. MOTHER'S NAME (First, Middle, Maiden Surname): Blanche Baskerville
19a. INFORMANT'S NAME (Type/Print): Andrea Brown
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2522 N. Ellamont St Balto, Md 21216
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery
20c. LOCATION — City or Town, State: Baltimore, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Martin K. Ehrlich
22. NAME AND ADDRESS OF FACILITY: March F. H. West 4300 Wabash Ave

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Multiple myeloma, stage III
DUE TO (OR AS A CONSEQUENCE OF):
c. anemia
DUE TO (OR AS A CONSEQUENCE OF):
d. DIC

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
renal failure
hypercalcemia
multiple bony metastases

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: J Weissbein, MD (Weissbein)
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 5/2/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3300 Wyman Park Drive, Balt, MD 21212
31. DATE FILED (Month, Day, Year): MAY 5 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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OHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be ... hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page ... be used for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

### TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William C. Lee
2. DATE OF DEATH — MONTH: 5 DAY: 1 YEAR: 89
3. TIME OF DEATH: 1135 PM
4. SOCIAL SECURITY NUMBER: 224-22-0594
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 64 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10/24/24
8. BIRTHPLACE (State or Foreign Country): Va
9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital of Baltimore
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3505 Woodland Ave
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Leroy Mert Construction
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Tom Lee
18. MOTHER'S NAME (First, Middle, Maiden Surname): Pearl Smith
19a. INFORMANT'S NAME (Type/Print): Thelma B. Lee
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3505 Woodland Ave Balto Md 21215
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): King Memorial Park
20c. LOCATION — City or Town, State: Randallstown, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Portia L Elson
22. NAME AND ADDRESS OF FACILITY: March F. H. West 4300 Wabash Ave

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Myocardial Infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 5 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 5 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Stephen O'Neil
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): 5/1/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sinai Hospital of Baltimore
31. DATE FILED (Month, Day, Year): MAY 4 - 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson

3

DHMH-15 Rev 1/89

89 11109

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11110

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Marie Theresa Lehmer | | | 2. DATE OF DEATH (Month, Day, Year): April 30, 1989 | 3. TIME OF DEATH: 4:28 p M |
| 4. SOCIAL SECURITY NUMBER: 218-12-4823 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Nov. 26 1924 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: ------ |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: ---- | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3857 Lyndale Avenue | | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5+): n/a | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): Edward H. Vogel | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Gladys Rose Obert | |
| 19a. INFORMANT'S NAME (Type/Print): Arden Lehmer (husband) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3857 Lyndale Ave. Baltimore, Md. 21213 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Md. 21213 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pulmonary Hypertension | |
| | DUE TO (OR AS A CONSEQUENCE OF): Tricuspid Regurgitation | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: J. Azar | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Azar, M.D. c/o Maryland General Hospital

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 4 - 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall |

DHMH-16 Rev 1/89

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89 11111

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Jimmy Lee | | | 2. DATE OF DEATH (Month, Day, Year): 4-27-89 | 3. TIME OF DEATH: 7:37AM M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS 4 DAYS — IF UNDER 24 HRS.: HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12 24 88 | 8. BIRTHPLACE (State or Foreign Country): Maryland |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): University Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Balto. City | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1316 W. North Ave. | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: B |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Vernon Lee | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lorraine Giddins |
| 19a. INFORMANT'S NAME (Type/Print): Lorraine Giddins | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1316 W North Ave Balto., MD 21217 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Mt Auburn Cemetery | 20c. LOCATION — City or Town, State: Balto., MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William C. Brown | 22. NAME AND ADDRESS OF FACILITY: 1206 W. North Ave Wm. C. Brown Comm. F. H. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sudden Infant Death Syndrome | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| ☒ YES 2 ☐ NO | ☒ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: ☒ 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-28-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201 VC | | |
| 31. DATE FILED (Month, Day, Year): MAY 10 1989 | 32. REGISTRAR'S SIGNATURE: [illegible] | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11112

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): IRENE A. LANGLEY
2. DATE OF DEATH (Month, Day, Year): 4 5 89
3. TIME OF DEATH: 4 25 pm
4. SOCIAL SECURITY NUMBER: 215-30-2165
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 56 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9/4/32
8. BIRTHPLACE (State or Foreign Country): Baltimore
9a. FACILITY NAME (If not institution, give street and number): SINAI Hospital of Balt
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Balt.
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3718 BEEHLER Ave
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Lawson, Early
18. MOTHER'S NAME (First, Middle, Maiden Surname): Inez Felder
19a. INFORMANT'S NAME (Type/Print): Inez Boone
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3718 Beehler Ave Baltimore, Md. 21215
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Nat. Cem.
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: March F/H West, 4300 Wabash Avenue

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio Pulmonary Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DIC | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Mansourian MD H.O.
29c. LICENSE NUMBER: 9455
29d. DATE SIGNED (Month, Day, Year): ▶ 4/5/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): MANSOURIAN SINAI Hospital of Baltimore M.D
31. DATE FILED (Month, Day, Year): 4/5/89
32. REGISTRAR'S SIGNATURE: APR 12 1989 Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

3

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11113
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): PHILIP LAPIN | | | 2. DATE OF DEATH (Month, Day, Year): APR. 6, 1989 | 3. TIME OF DEATH: 8:05 AM M |
| 4. SOCIAL SECURITY NUMBER: 077-30-8352 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): NOV.8,1912 | 8. BIRTHPLACE (State or Foreign Country): RUSSIA |
| 9a. FACILITY NAME (If not institution, give street and number): 6942 MILBROOK PARK DR., APT. T-3 | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: Baltimore |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BaHO. | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 6942 MILBROOK PARK DR., APT. T-3 | | 10f. ZIP CODE: 21215 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 3rd year | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CLERK | | 16b. KIND OF BUSINESS/INDUSTRY: CITY GOVERNMENT |
| 17. FATHER'S NAME (First, Middle, Last): JACOB LAPIN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA GOLDBERG | | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. RUTH LAPIN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6942 MILBROOK PARK DR.,APT. T-3 BALTO., MD 21215 | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [XX] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CEDAR PARK-BETH EL | | 20c. LOCATION — City or Town, State: PARAMUS, NJ |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jay Lewis | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary Arrest | minutes |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): ASCVD (arteriosclerotic Cardiovascular Disease) | uncertain |
| | c. DUE TO (OR AS A CONSEQUENCE OF): Hypercholesterolemia | years. |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Bernard F Kozlovsky

29c. LICENSE NUMBER: D26473

29d. DATE SIGNED (Month, Day, Year): ▶ 4/5/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Bernard F KOZLOVSKY, MD 6804 OAKN Heights 21215

31. DATE FILED (Month, Day, Year): APR 12 1989

32. REGISTRAR'S SIGNATURE: Erika Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11114.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LILLIAN MAY LARABEE

2. DATE OF DEATH — MONTH: 4 DAY: 16 YEAR: 89

3. TIME OF DEATH: 4:00 AM M

4. SOCIAL SECURITY NUMBER: 214-01-2206

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 12/7/~~80~~ 08

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore city

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Arbutus

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 4732 Gateway Terrace

10f. ZIP CODE: 21227

10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): Elementary — College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker

16b. KIND OF BUSINESS/INDUSTRY: ---

17. FATHER'S NAME (First, Middle, Last): David C. King

18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Bortle

19a. INFORMANT'S NAME (Type/Print): Kenneth L. Williams

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7514 - A Sweet Hours Way Columbia, Md. 21046

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery

20c. LOCATION — City or Town, State: Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jackie D. Shannon.

22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute myocardial infarction complicated by arrhythmia, probable — DUE TO (OR AS A CONSEQUENCE OF): — hours

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Hypertensive arteriosclerotic cardiovascular disease — DUE TO (OR AS A CONSEQUENCE OF): — years

c. — DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Acute cardio-right femoral embolism

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Laurence R Gallagher MD

29c. LICENSE NUMBER: D 01786

29d. DATE SIGNED (Month, Day, Year): ▶ 4-16-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LAURENCE R GALLAGER, MD, ST AGNES MED. CTR., WILKENS & PINE HTS, BALTO MD 21229

31. DATE FILED (Month, Day, Year): APR 20 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Landeck

DNMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11115
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): John H Leach | | | | | 2. DATE OF DEATH: MONTH 4-21-89 DAY YEAR | 3. TIME OF DEATH: 5:10PM M |
| 4. SOCIAL SECURITY NUMBER: 240-32-2048 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 61 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3-4-28 | 8. BIRTHPLACE (State or Foreign Country): North Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): 606 Cherrycrest Road | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 606 Cherrycrest Rd | 10f. ZIP CODE: 21225 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): David Leach | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Molly Murphy |
| 19a. INFORMANT'S NAME (Type/Print): Ms Louise Jeffrey | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 831 Roundview Rd Balto Md 21225 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt Zion Cem. 4-25-89 | 20c. LOCATION — City or Town, State: Balto. Co. Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph L. Russ | 22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ 2222 W. North Ave. Balto. Md. 21216 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or reapiretory arrest, shock, or heart failure. List only ona ceuse on sach line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES ☒ NO INSPECTION | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES ☒ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home ☒ 5 Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: ☒ 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-22-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Margarita A. Korell, M.D. 111 Penn Street, Baltimore, MD 21201 VC

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 28 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11116

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MASIUS, Leah W.
2. DATE OF DEATH: MONTH 4 DAY 17 YEAR 89
3. TIME OF DEATH: 9:15 p M
4. SOCIAL SECURITY NUMBER: 216-46-4681
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 88 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 8/19/1900
8. BIRTHPLACE (State or Foreign Country): Hebron, Md.

9a. FACILITY NAME (If not institution, give street and number): Keswick Home
9b. CITY, TOWN OR LOCATION OF DEATH: Balt
9c. COUNTY OF DEATH: Balt

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Balt
10c. CITY, TOWN OR LOCATION: Balt
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 700 W 40th St
10f. ZIP CODE: 21211
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: Own Home

17. FATHER'S NAME (First, Middle, Last): Ballard Wilson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Phillips

19a. INFORMANT'S NAME (Type/Print): Alfred G. Masius
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3024 N. Calvert St. Apt E2 Balto. Md. 21218

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
20c. LOCATION — City or Town, State

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John B. Slade
22. NAME AND ADDRESS OF FACILITY: Henry W. Jenkins & Sons 4905 York Rd. Baltimore, Md. 21212

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer's disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M. Isabelle MacGregor MD
29c. LICENSE NUMBER: D13657
29d. DATE SIGNED (Month, Day, Year): ▶ April 17, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M. ISABELLE MACGREGOR, KESWICK, 700 W 40th Street, Balto. Md 21211

31. DATE FILED (Month, Day, Year): APR 21 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 11116

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11117

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BEATRICE T Lee
2. DATE OF DEATH (Month, Day, Year): 4 25 89
3. TIME OF DEATH: 6:20A M
4. SOCIAL SECURITY NUMBER: 217-12-0676
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-4-1910
8. BIRTHPLACE (State or Foreign Country): WEST VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): Deaton Hospital + Med Ctr
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore MD.
9c. COUNTY OF DEATH: City.

**RESIDENCE OF DECEDENT**

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? XX 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1213 GLENWOOD AVENUE
10f. ZIP CODE: 21239
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 8th Grade — College (1-4 or 8 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Seamstress
16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): LUTHER THORNTON
18. MOTHER'S NAME (First, Middle, Maiden Surname): MAGGIE SHARP
19a. INFORMANT'S NAME (Type/Print): JESSIE LEE
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1213 GLENWOOD AVENUE/BALTIMORE, MD 21239
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK CEMETERY
20c. LOCATION — City or Town, State: ARBUTUS, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vanessa Davis
22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Urosepsis + Renal Failure | 1 day |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Decubitus ulcers | month |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Diabetes Mellitus | 8yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: E. J. Folkmar M.D.
29c. LICENSE NUMBER: D14571
29d. DATE SIGNED (Month, Day, Year): ▶ 4/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Folkmar — DEATON Hospital.
31. DATE FILED (Month, Day, Year): APR 28 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11118

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Irmalee Lenczycki | | | 2. DATE OF DEATH (Month, Day, Year): April 02, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): April 02, 1899 | 8. BIRTHPLACE (State or Foreign Country): Georgia |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital CPER | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Howard | 10c. CITY, TOWN OR LOCATION: Elkridge | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 6378 Old Washington Blvd. | | 10f. ZIP CODE: 21227 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 1 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): clerk | 16b. KIND OF BUSINESS/INDUSTRY: gov't. |
| 17. FATHER'S NAME (First, Middle, Last): James A. Dickinson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Amanda L. Johnson | |
| 19a. INFORMANT'S NAME (Type/Print): William J. Lenczycki | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4922 Leeds Avenue 21227 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Douglasville Cemetry | 20c. LOCATION — City or Town, State: Douglasville, Georgia |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Ambrose Funeral Home 1328 Sulphur Spring Rd. 21227 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the dasth. Do not enter the moda of dying, such as cardiac or reapiratory arrest, shock, or haart failure. List only one cause on aach lina.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio-pulmonary Arrest | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Acute Coronary Suspect | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. AS CVD | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D. | 29c. LICENSE NUMBER: D-19528 | 29d. DATE SIGNED (Month, Day, Year): 4/3/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Cayoso 5411 Old Frederick Road | | | |
| 31. DATE FILED (Month, Day, Year): APR 4 1989 | 32. REGISTRAR: [signature] | | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11119
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| CATHERINE | MARIE | LINTON | 4/15/1989 | 6:45 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-14-1189 | 1 ☐ M 2 ☒ F | 68 YRS. | | | 2/27/1921 | Md. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 3712 Second Street, 21225 | Baltimore City | --- |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | --- | Baltimore | ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 3712 Second Street, | 21225 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: | 14. RACE — American Indian, Black, White, etc. Specify: |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO | White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 8 +) | | |
| 10 | | Homemaker | Domestic |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Carroll W. White | Mary Anderson |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Edward Joseph Linton, Sr. | 3712 Second St., Baltimore, Md. 21225 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Cedar Hill Cemetery | Baltimore, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Kevin E. Ecker | McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hepatic Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Metastatic Breast Cancer to Liver | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☑ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☑ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| John H. Fetting M.D. | D18320 | ▶ April 17, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
John H. Fetting M.D. Johns Hopkins Oncology Center 600 N. Wolfe St Baltimore 21205-MD

| DATE FILED (Month, Day, Year) | REGISTRAR'S SIGNATURE |
|---|---|
| APR 20 1989 | Julia Gordon-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11120

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Calvin Lipscomb
2. DATE OF DEATH: MONTH 4 DAY 14 YEAR 89
3. TIME OF DEATH: 2:45 P M
4. SOCIAL SECURITY NUMBER: 378-12-9962
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 72 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 3/21/17
8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3513 W. BELVEDERE AVE.
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY: US
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ELEVATOR OPERATOR
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): JAMES LIPSCOMB
18. MOTHER'S NAME (First, Middle, Maiden Surname): OTELIA
19a. INFORMANT'S NAME (Type/Print): DELORES BOSWELL
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3513 W. BELVEDERE AVE. BALTIMORE, MD. 21215
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VET.
20c. LOCATION — City or Town, State: OWINGS MILLS, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Marcella Hecht #281
22. NAME AND ADDRESS OF FACILITY: E.L. PHILLIPS FUNERAL HOME 1721 N. MONROE STREET 21217

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiac arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Vicki Hutton, MD
29c. LICENSE NUMBER: 9465
29d. DATE SIGNED (Month, Day, Year): 4/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sinai Hospital Belvedere & Greenspring Ave
31. DATE FILED (Month, Day, Year): APR 24 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendrick

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11121

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Edgar Lievers | | | 2. DATE OF DEATH (Month, Day, Year): 04 30 89 | 3. TIME OF DEATH: 1425 M |
| 4. SOCIAL SECURITY NUMBER: 214 03 0730 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 95 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 07 15 93 | 8. BIRTHPLACE (State or Foreign Country): BALTO., MD. |
| 9a. FACILITY NAME (If not institution, give street and number): UNIV. OF MARYLAND | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: BALTIMORE |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MD | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 501 W. FRANKLIN ST. | | 10f. ZIP CODE: 21201 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RETIRED | | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): FRANK H. LIEVERS | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY E. LAWRENCE | | |
| 19a. INFORMANT'S NAME (Type/Print): MARGARET LIEVERS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 108 SOUTH CATHERINE STREET (21223) | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. CALVARY CEMETERY | | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Annette K. Jones | | 22. NAME AND ADDRESS OF FACILITY: BROWN-THOMPSON F.H. P.O. BOX 4433 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Probable Sepsis | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Colon Cancer | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizures
U.T.I.'S
Anemia

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Angela Corbin MD | 29c. LICENSE NUMBER: D12453 | 29d. DATE SIGNED (Month, Day, Year): 4/30/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Univ. Of Md. 22 South Greene St. Balt. Md 21201 | | |
| 31. DATE FILED (Month, Day, Year): MAY 4 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11122
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): ELISE LIPTON

**2. DATE OF DEATH** (Month, Day, Year): APRIL 17, 1989

**3. TIME OF DEATH**: 3:30 AM M

**4. SOCIAL SECURITY NUMBER**: 217-20-7952

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 81 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 9-23-07

**8. BIRTHPLACE** (State or Foreign Country): MARYLAND

**9a. FACILITY NAME** (If not institution, give street and number): 3900 N. CHARLES ST. APT. 1210

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTIMORE

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: MARYLAND

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: BALTIMORE

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 3900 N. CHARLES ST., APT. 1210

**10f. ZIP CODE**: 21218

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: WHITE

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE

**16b. KIND OF SUSINESS/INDUSTRY**: AT HOME

**17. FATHER'S NAME** (First, Middle, Last): DR. LEE COHEN

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): LILYAN RICE

**19a. INFORMANT'S NAME** (Type/Print): WILLIAM B. WOLF, SR.

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7121 PARK HTS. AVE., APT. 909 BALTO., MD 21215

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): DRUID RIDGE

**20c. LOCATION — City or Town, State**: BALTIMORE - MD

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Sydney L. Stillman

**22. NAME AND ADDRESS OF FACILITY**: SOL LEVINSON & BROS.
6010 REISTERSTOWN RD. BALTO., MD. (21215)

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CEREBRAL THROMBOSIS | 3 DAYS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | HYPERTENSION | 15 yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: BREAST CARCINOMA (1986)

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year):

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**:

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify):

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Herbert A. Bierstock

**29c. LICENSE NUMBER**: D00509

**29d. DATE SIGNED** (Month, Day, Year): ▶ APRIL 17/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): DR BERSTOCK. 302 E 33RD ST BALTO. 21218

**31. DATE FILED** (Month, Day, Year): APR 20 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11123

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lucy J. Pierce Little
2. DATE OF DEATH (Month, Day, Year): 4-17-89
3. TIME OF DEATH: 7:00PM M
4. SOCIAL SECURITY NUMBER: 225-18-2337
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 73 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 8 28 1915
8. BIRTHPLACE (State or Foreign Country): N.C.
9a. FACILITY NAME (If not institution, give street and number): 2151 Vine Street
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2151 W. Vine Street
10f. ZIP CODE: 21223
10g. CITIZEN OF WHAT COUNTRY? U S A
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): James Pierce
18. MOTHER'S NAME (First, Middle, Maiden Surname): Charity Whitehead
19a. INFORMANT'S NAME (Type/Print): Ruth Haliday
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1637 Warwick Avenue Baltimore, Md 21217
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park
20c. LOCATION — City or Town, State: Arbutus, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypertensive arteriosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO — INSPECTION

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ 4-18-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. KOkes, M.D. 111 Penn Street, Baltimore, MD 21201 VC

31. DATE FILED (Month, Day, Year): APR 21 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

88 11153

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11124
REG. NO.

4

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GORDON LOEB — GORDON LOEB | | | 2. DATE OF DEATH (Month / Day / Year): 4 / 29 / 89 | 3. TIME OF DEATH: 4:24 PM |
| 4. SOCIAL SECURITY NUMBER: 180-16-5163 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 66 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 4/4/23 | 8. BIRTHPLACE (State or Foreign Country): PENNA. |
| 9a. FACILITY NAME (If not institution, give street and number): SINAI Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH | | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: PIKESVILLE | 10d. INSIDE CITY LIMITS? [ ] YES [X] NO | |
| 10e. STREET AND NUMBER: 8 POMONA SOUTH | 10f. ZIP CODE: 21208 | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII ARMY | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 8+): 4 YRS. | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CHEMIST | 16b. KIND OF BUSINESS/INDUSTRY: ROCKLAND INDUSTRIES | |
| 17. FATHER'S NAME (First, Middle, Last): JOSEPH LOEB | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): DORA COHEN | | |
| 19a. INFORMANT'S NAME (Type/Print): JEAN LOEB | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 POMONA SOUTH APT. 8 Baltimore, md. (21208) | | |
| 20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. SHARON CEMETERY | 20c. LOCATION — City or Town, State: SPRINGFIELD, DEL. CO. PA. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215) | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SEPSIS | 1 WEEK |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. PERFORATED DIVERTICULITIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. PANDEMIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. COPD | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Ian M. Weiner MD | AS2402321-IW-9484 | ▶ 4/29/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): IAN M. WEINER - SINAI Hosp.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 2 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11125
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THEODORE LEE LOGUE SR.
2. DATE OF DEATH: MONTH 4 DAY 17 YEAR 89
3. TIME OF DEATH: 7:34 P M
4. SOCIAL SECURITY NUMBER: 578-38-4026
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 62 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 4/06/27
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital 900 S. Caton Ave
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, MD 21229
9c. COUNTY OF DEATH: --

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: CATONSVILLE
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 5 Maple Drive
10f. ZIP CODE: 21228
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5 +): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ELECTRONIC MECHANIC
16b. KIND OF BUSINESS/INDUSTRY: U.S. POST OFFICE
17. FATHER'S NAME (First, Middle, Last): RUSSELL LOGUE
18. MOTHER'S NAME (First, Middle, Maiden Surname): EMMA VANBUREN
19a. INFORMANT'S NAME (Type/Print): JANET F. LOGUE
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 MAPLE DRIVE, CATONSVILLE, MARYLAND 21228
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VETERANS
20c. LOCATION — City or Town, State: OWINGS MILLS, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Left main coronary artery thrombosis | hrs. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Coronary artery disease | years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Bert F. Morton, M.D.
29c. LICENSE NUMBER: D 08949
29d. DATE SIGNED (Month, Day, Year): 4/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): St. Agnes Hospital 900 South Caton Avenue Baltimore 21229
31. DATE FILED (Month, Day, Year): APR 24 1989
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

89 1125

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11126

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): LEE R. LOVE

**2. DATE OF DEATH** MONTH 4 DAY 22 YEAR 89

**3. TIME OF DEATH**: M

**4. SOCIAL SECURITY NUMBER**: 215-18-8517

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 68 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 4-6-21

**8. BIRTHPLACE** (State or Foreign Country): MD

**9a. FACILITY NAME** (If not institution, give street and number): ST. AGNES

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTIMORE

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD

**10b. COUNTY**: BALTIMORE

**10c. CITY, TOWN OR LOCATION**: HALETHORPE

**10d. INSIDE CITY LIMITS?** 1 [ ] YES 2 [X] NO

**10e. STREET AND NUMBER**: 5702 1st Ave.

**10f. ZIP CODE**: 21227

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A

**11. MARITAL STATUS** 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): SPINNER OPERATOR

**16b. KIND OF BUSINESS/INDUSTRY**: DAVIS HEMP

**17. FATHER'S NAME** (First, Middle, Last): LEE R. LOVE SR.

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): NELLIE MAE ORT

**19a. INFORMANT'S NAME** (Type/Print): LEAH LOVE

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5702 1st AVE HALETHORPE MD 21227

**20a. METHOD OF DISPOSITION** 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): WESTVIEW

**20c. LOCATION — City or Town, State**: CATONSVILLE

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Harry H. Witzke

**22. NAME AND ADDRESS OF FACILITY**: 4112 COLUMBIA PK. ELLICOTT CITY MD 21043

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Myocardial Infarction | IMMED. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | COPD | Months |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | ASCVD | YRS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | HBP | YRS |

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [ ] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [X] NO

**26. PLACE OF DEATH** (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH** 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRISE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one) 1 [X] CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: C. J. Tolken, MD.

**29c. LICENSE NUMBER**: D-14571

**29d. DATE SIGNED** (Month, Day, Year): ▶ 4/24/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print)

**31. DATE FILED** (Month, Day, Year): APR 25 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11127 REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ruth Lucas
2. DATE OF DEATH: MONTH 4 DAY 18 YEAR 89
3. TIME OF DEATH: 9:29 A M
4. SOCIAL SECURITY NUMBER: 217-22-2892
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 75 YRS. | IF UNDER 1 YEAR: MONTHS DAYS | IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 2-14-14
8. BIRTHPLACE (State or Foreign Country): TEXAS
9a. FACILITY NAME (If not institution, give street and number): Montebello Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore City

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2327 Reisterstown Road
10f. ZIP CODE: 21217
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 8+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Beautician
16b. KIND OF BUSINESS/INDUSTRY: Self-Employed
17. FATHER'S NAME (First, Middle, Last): Emanuel Watson
18. MOTHER'S NAME (First, Middle, Maiden Surname): ? Newsome
19a. INFORMANT'S NAME (Type/Print): Maurine Williams
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4312 Castor Houston Texas 77022
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): McDonald Cemetery
20c. LOCATION — City or Town, State: Chapel Hill Tex.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Rona Adams Jones
22. NAME AND ADDRESS OF FACILITY: Marshall W. Jones, Jr. Funeral Home PA 4101 Edmondson Avenue

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Accident (Right)
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Hypertension
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Aleyamma J. Mathew M.D.
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 4-18-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALEYAMMA J. MATHEW - Montebello Hosp. 2201 ARGONNE DR. 21218
31. DATE FILED (Month, Day, Year): APR 21 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11128

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH LUNN, SR
2. DATE OF DEATH (Month, Day, Year): 4 12 89
3. TIME OF DEATH: 6 30 AM
4. SOCIAL SECURITY NUMBER: 250-28-4211
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 64 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9/3/24
8. BIRTHPLACE (State or Foreign Country): S.C.
9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: B

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Balt. more
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2729 Guilford Ave
10f. ZIP CODE: 21218
10g. CITIZEN OF WHAT COUNTRY?
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 6+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY: Plumming Supply
17. FATHER'S NAME (First, Middle, Last): Robert Lunn
18. MOTHER'S NAME (First, Middle, Maiden Surname): Georgian Black
19a. INFORMANT'S NAME (Type/Print): Katie M. Lunn
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2729 Guilford Ave Baltimore md 21218
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery
20c. LOCATION — City or Town, State: Baltimore, md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Willard Edmonds
22. NAME AND ADDRESS OF FACILITY: March F.H. West 4300 Wabash Ave

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIO PULMONARY ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. SEPSIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Carol J Levi
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 4/12/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CAROL J LEVI SINAI HOSPITAL, BALTIMORE
31. DATE FILED (Month, Day, Year): 4/13/1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11129
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Baby Boy (WIGGINS) Timothy Jamal Lawson

**2. DATE OF DEATH** (Month, Day, Year): 4 / 26 / 89

**3. TIME OF DEATH**: 9:00 P M

**4. SOCIAL SECURITY NUMBER**: NONE

**5. SEX**: 1 ☑ M 2 ☐ F

**6. AGE** (In yrs. last birthday): YRS.
IF UNDER 1 YEAR: MONTHS 1 / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 4-24-89

**8. BIRTHPLACE** (State or Foreign Country): Maryland

**9a. FACILITY NAME** (If not institution, give street and number): MERCY MEDICAL CENTER

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTIMORE

**9c. COUNTY OF DEATH**: Baltimore City

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD

**10b. COUNTY**: Baltimore City

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 ☑ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 1909 Brunt Street

**10f. ZIP CODE**: 21217

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☑ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☑ NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: Black

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): NONE
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Child-infant

**16b. KIND OF BUSINESS/INDUSTRY**: Na

**17. FATHER'S NAME** (First, Middle, Last): Lawson-Walter Jr. Lawson

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Sharon Wiggins

**19a. INFORMANT'S NAME** (Type/Print): Sharon Wiggins

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1909 Brunt St/Balto. MD. 21217

**20a. METHOD OF DISPOSITION**: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): King Mem PK. Cem

**20c. LOCATION — City or Town, State**: Randallstown, MD.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Gladys Warner

**22. NAME AND ADDRESS OF FACILITY**: William C. March F.H. 1101 E. North Ave

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not anter tha mode of dying, such as cardiac or raapiratory arrest, shock, or heart failure. List only one cause on each line.**

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Respiratory Distress Syndrome | 1 day |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Extreme Prematurity | 1 day |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☐ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☐ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: M. Redwood MD Pediatric Resident

**29c. LICENSE NUMBER**:

**29d. DATE SIGNED** (Month, Day, Year): ▶ 4-26-89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Stephen G. Bolton NEONATAL NURSE Practitioner MERCY MEDICAL CENTER

**31. DATE FILED** (Month, Day, Year): MAY 1 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 11129

Item 23 part I & II corrected per Med. Exam.
Film G-655 09/16/89 pjt

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11130

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): William AKA: JAMES B. WADE,JR. Logan,Jr. | | | 2. DATE OF DEATH (Month, Day, Year): 4-21-89 | 3. TIME OF DEATH: 12:28PM M |
| 4. SOCIAL SECURITY NUMBER: 218-64-0657 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 57 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 3/9/32 | 8. BIRTHPLACE (State or Foreign Country): VA. |
| 9a. FACILITY NAME (If not institution, give street and number): 1000 N. Mount Street | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1000 N. MOUNT STREET | | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A | 16b. KIND OF BUSINESS/INDUSTRY: N/A | |
| 17. FATHER'S NAME (First, Middle, Last): JAMES B. WADE, SR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): BESSIE LOGAN | |
| 19a. INFORMANT'S NAME (Type/Print): BESSIE WADE | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. BOX 475 BUCHANAN, VA. 24066 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. REST CEMETERY | 20c. LOCATION — City or Town, State: HANOVER, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warren | 22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH FUNERAL HOME 1101 E. NORTH AVENUE | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Complications of Baterial Endocarditis, and Cirrhosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. Bronchopneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Intravenous drug abuse and HIV infection (positive AIDS TEST) test

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) / 26b. TIME OF INJURY / 26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 26d. DESCRIBE HOW INJURY OCCURED | |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) / 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-22-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan,M.D. | | 111 Penn Street,Baltimore,MD 21201 |
| 31. DATE FILED (Month, Day, Year): APR 26 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson Lindsay | |

4+1 vc

DHMH-16 Rev 1/89

88 11130

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11131
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): ~~LOS~~ BILLY F. LOGAN

**2. DATE OF DEATH** MONTH 04 / DAY 07 / YEAR 89

**3. TIME OF DEATH**: 0012 A M

**4. SOCIAL SECURITY NUMBER**: 091-46-1284

**5. SEX**: 1 [X] M 2 [ ] F

**5. AGE** (In yrs. last birthday): 78 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 11/19/10

**8. BIRTHPLACE** (State or Foreign Country): Mass.

**9a. FACILITY NAME** (If not institution, give street and number): Loch Raven VA Hospital

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 [X] YES 2 [ ] NO

**10e. STREET AND NUMBER**: Pleasant Manor Nursing Home

**10f. ZIP CODE**: 21215

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.

**11. MARITAL STATUS**: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: 10/14/41 - 10/15/46

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 8+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Panhandler

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): William Logan

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Edith Coliowski

**19a. INFORMANT'S NAME** (Type/Print): Loch Raven VA Hospital

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3900 Loch Raven Blvd

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Garrison-Forrest Veterans

**20c. LOCATION — City or Town, State**: Owings Mills MD

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE** ▶

**22. NAME AND ADDRESS OF FACILITY**: Irvin Carroll Funeral Home, 1712-14 W. North Avenue

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | PNEUMONIA | 3 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | YEARS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | PERIPHERAL VASCULAR DISEASE | YEARS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | ETHANOL ABUSE | YEARS |

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**
Atrial fib/flutter, Chronic Obstructive Pulmonary Disease, H/o LEVINE shunt, h/o (L) hip disarticulation & mult mtx.

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [ ] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [ ] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 8 [ ] Residence 8 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending investigation 8 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year):

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**:

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify):

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: MR0264 STAFF PHYSICIAN

**29c. LICENSE NUMBER**: [redacted]

**29d. DATE SIGNED** (Month, Day, Year) ▶ 4/7/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): B.L. FELDMAN, 3900 LOCH RAVEN BLVD.

**31. DATE FILED** (Month, Day, Year): APR 7 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DNMN-18 Rev 1/89

89 11131

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11132
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Errol Lyn | 2. DATE OF DEATH (Month, Day, Year): 4-21-89 | 3. TIME OF DEATH: 12:23AM M | |
| 4. SOCIAL SECURITY NUMBER: 073-54-6044 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 29 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 3-27-60 |
| 8. BIRTHPLACE (State or Foreign Country): Jamaica | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1106 Sandystone Road #E | 10f. ZIP CODE: | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Propietor | 16b. KIND OF BUSINESS/INDUSTRY: Store |
| 17. FATHER'S NAME (First, Middle, Last): Harry Lyn [illegible] | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Gloria Bailey | |
| 19a. INFORMANT'S NAME (Type/Print): Vicki Evans | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1106 Sandystone Road | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Local Cemetary | 20c. LOCATION — City or Town, State: Manchester, Jamaica |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Carlton C. Douglas | 22. NAME AND ADDRESS OF FACILITY: Carlton C. Douglass F/S 1701 McCulloh St Balto., Md | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Gunshot wounds of chest and forearm | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 26a. DATE OF INJURY (Month, Day, Year): 4-20-89 | 26b. TIME OF INJURY: 11:55PM | 26c. INJURY AT WORK? 1 [ ] YES [X] NO | 26d. DESCRIBE HOW INJURY OCCURED: subject shot |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): street | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 5700 block Radecke Avenue |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-21-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201 VC

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 25 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landeau |

DHMH-16 Rev 1/89

89 11133

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) LILLIAN A. LEWANDOWSKI | | | 2. DATE OF DEATH MONTH 4 DAY 23 YEAR 89 | 3. TIME OF DEATH 10P M |
| 4. SOCIAL SECURITY NUMBER 215-12-4880 | 5. SEX 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday) 66 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 03-08-23 | 8. BIRTHPLACE (State or Foreign Country) BALTO MD. |
| 9a. FACILITY NAME (If not institution, give street and number) CHURCH HOSPITAL Fairmount Nursing Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Balto City |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE Md | 10b. COUNTY Baltimore | 10c. CITY, TOWN OR LOCATION Essex | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO |
| 10e. STREET AND NUMBER 1051 FOXCHASE ROAD | | 10f. ZIP CODE 21221 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: White | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesperson | 16b. KIND OF BUSINESS/INDUSTRY Salvation Army |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last) Henry F. Rode | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura Elizabeth Davis |
| 19a. INFORMANT'S NAME (Type/Print) Frederick H. Kotrla | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1051 Foxchase Road Balto. Md. 21221 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery | 20c. LOCATION — City or Town, State Baltimore Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Connelly Funeral Home | 22. NAME AND ADDRESS OF FACILITY ConnellyFuneralHome 300MAceAve. 21221 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ENDOMETRIAL CARCINOMA WITH METASTASES to LUNGS/LIVER | 3 MONTHS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DM

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER Compliance MD | 29c. LICENSE NUMBER D16619 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4-23-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 700 N. BROADWAY BALTIMORE, MARYLAND 21231 | | |
| 31. DATE FILED (Month, Day, Year) APR 26 1989 | 32. REGISTRAR'S SIGNATURE Julia Davidson-Landale | |

DHMH-18 Rev 1/89

89 11134

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HERMAN PHILIP LACY | | | 2. DATE OF DEATH (Month, Day, Year): Apr. 25, 1989 | 3. TIME OF DEATH: 4;25A M |
| 4. SOCIAL SECURITY NUMBER: 213-28-5349 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Dec. 25, 1915 | 8. BIRTHPLACE (State or Foreign Country): Va. |
| 9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: None |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: W. Va. | 10b. COUNTY: None | 10c. CITY, TOWN OR LOCATION: Wheeling | 10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1113 McCulloch Street | | 10f. ZIP CODE: 26003 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Groomer | 16b. KIND OF BUSINESS/INDUSTRY: Horse Racing | |
| 17. FATHER'S NAME (First, Middle, Last): Moses William Lacy | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Abbie Washington | |
| 19a. INFORMANT'S NAME (Type/Print): Peggy A. Lee | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9410 Chatham St. Manassas, Va. 22110 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Morris Cemetery | 20c. LOCATION — City or Town, State: Hume, Va. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bernard O'Hara | 22. NAME AND ADDRESS OF FACILITY: Ames Funeral Home 8914 Quarry Rd. Manassas, Va. 22110 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Possible myocardial infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Possible pulmonary embolism | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Small bowel obstruction

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☑ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Miles G. Harrison Jr. | 29c. LICENSE NUMBER: D24783 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/25/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Miles G. Harrison JS. Sinai Hospital | | |
| 31. DATE FILED (Month, Day, Year): MAY 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 11135

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Willie W. Leak
2. DATE OF DEATH (Month, Day, Year): 4-30-89
3. TIME OF DEATH: 4:24PM M
4. SOCIAL SECURITY NUMBER: 218 18 8141
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 65 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3/15/24
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): 1417 N. Fulton Avenue
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: none

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: none
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1417 Fulton Avenue
10f. ZIP CODE: 21217
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WWII
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+): Tech.
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer Electronics Eng.
16b. KIND OF BUSINESS/INDUSTRY: Glenn L. Martin Corp
17. FATHER'S NAME (First, Middle, Last): ~~Unk~~ John Leak
18. MOTHER'S NAME (First, Middle, Maiden Surname): Jessie Pyles
19a. INFORMANT'S NAME (Type/Print): Bernadette Byrd
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1701 Appleton St. Balto., Md. 21217
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest
20c. LOCATION — City or Town, State: Balto., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Juanita B. Morton
22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons, 1701 Laurens St. Balto., Md. 21217

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic alcoholism

24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) — 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ 5-1-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan, M.D. 111 Penn Street, Baltimore, MD 21201 VC
31. DATE FILED (Month, Day, Year): MAY 3 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11136
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| BERTHA | A. | LEWANDOWSKI | APRIL 23, 1989 | M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-01-6752 | 1 ☐ M 2 ☒ F | 95 YRS. | | | March 8, 1894 | Poland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Long Green Nursing home | Baltimore | --- |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Baltimore | Timonium | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 408 Ivy Church Road | 21093 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: | 14. RACE — American Indian, Black, White, etc. Specify: |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO | White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5 +) | | |
| 6th grade | | Homemaker | Own Home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Joseph Kolakowski | Maryanne Kolakowski |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Leona D. Morris | 408 Ivy Church Road Timonium, Maryland 21093 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____ | Holy Rosary Cemetery | Baltimore, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ [signature] | Ruck Towson Funeral Home, Inc. 1050 York Road Baltimore, Maryland 21204 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. AS & D | 5 + yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D-09383 | ▶ 24 Apr 89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Charles F. O'Donnell MD - 7501 York Rd - Towson MD 21204

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 25 1989 | [signature] |

DHMH-16 Rev 1/89

10 DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 11136

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11137

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Rosemary Lawson | | 2. DATE OF DEATH (Month, Day, Year): 4-20-89 | 3. TIME OF DEATH: 10:25PM M |
| 4. SOCIAL SECURITY NUMBER: 213-09-3739A | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 37 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11/25/1951 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Bon Secours Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Dundalk | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1124 Old North Point Road | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dependent | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Thomas Rueben Lawson | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary E. Benczkowski | | |
| 19a. INFORMANT'S NAME (Type/Print): Thomas Rueben Lawson, Jr. | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1124 Old North Point Road | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial 4/24/89 | 20c. LOCATION — City or Town, State: Baltimore Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Baltimore, MD 21222 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Seizure disorder

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Congenital deformity

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-21-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Julia C. Goodin, M.D. | | 111 Penn Street, Baltimore Co, MD 2120[illegible] |
| 31. DATE FILED (Month, Day, Year): APR 25 1989 | 32. REGISTRAR'S SIGNATURE: [signature] | |

VC

DHMH-16 Rev 1/89

89 11138

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): SARA LEVY | | | 2. DATE OF DEATH (Month, Day, Year): 4 25 89 | 3. TIME OF DEATH: 8:15 A M |
| 4. SOCIAL SECURITY NUMBER: 216-24-3191 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS — DAYS —; IF UNDER 24 HRS.: HOURS — MIN. —) | 7. DATE OF BIRTH (Month, Day, Year): 9-27-98 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): Levindale Geriatric Center + Hosp. | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6152 GREENMEADOW PARKWAY | | 10f. ZIP CODE: 21209 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SALESLADY | 16b. KIND OF BUSINESS/INDUSTRY: RETAIL | |
| 17. FATHER'S NAME (First, Middle, Last): NATHAN TOBACK | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CELIA SHERR | |
| 19a. INFORMANT'S NAME (Type/Print): NORMA SNEIDER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6519 EDENVALE RD. 21209 BALTIMORE, MD | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ANSHE EMUNAH CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joel D Levin | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. GASTRO INTESTINAL BLEEDING | 3 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. POSSIBLE DISSEMINATED INTRAVASCULAR COAGULATION | 3 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. PNEUMONIA | 3 weeks |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE
DEMENTIA
CEREBRO VASCULAR ACCIDENT

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MA ATTENDING | 29c. LICENSE NUMBER: D30951 | 29d. DATE SIGNED (Month, Day, Year): 4-25-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. J. LUCCO, MA; 2434 W BELVEDERE AVE; BALTO 21215-5294 | | |
| 31. DATE FILED (Month, Day, Year): MAY 2 - 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11139
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Louis Lesser | | | 2. DATE OF DEATH (Month / Day / Year): 4 / 29 / 89 | 3. TIME OF DEATH: 11:30 P.M. |
| 4. SOCIAL SECURITY NUMBER: 219-12-9964 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 77 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 10/14/11 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 8a. FACILITY NAME (If not institution, give street and number): Sinai Hosp. of Balto Inc | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: Balto City | | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: — | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3211 Taney Rd. | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TAVERN OWNER | 16b. KIND OF BUSINESS/INDUSTRY: LIQUOR | |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): MAX LESSER | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Toba Dena Unknown |
| 19a. INFORMANT'S NAME (Type/Print): Sylvia Lesser | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3211 Taney Rd. Balt. MD 21215 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Beth Jacob Cemetery | 20c. LOCATION — City or Town, State: Finksburg, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael P Marullo | 22. NAME AND ADDRESS OF FACILITY: HEBREW Memorial Funeral Home, Inc 1100 Reisterstown Rd-Balt, MD 21208 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary arrest
DUE TO (OR AS A CONSEQUENCE OF):
Acute Myocardial infarction

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: H. Ronald Friedman MD | 29c. LICENSE NUMBER: D01703 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/1/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): H. Ronald Friedman MD 6715 Park Hts Ave. Balt, Md 21215 | | |
| 31. DATE FILED (Month, Day, Year): MAY 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page [illegible] the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral di[illegible] be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner [illegible] at once.**

89 11140

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): IRENE LOECHER / IRENE A. LOECHER | | | 2. DATE OF DEATH (Month / Day / Year): 4 / 5 / 89 | 3. TIME OF DEATH: 12:50 PM |
| 4. SOCIAL SECURITY NUMBER: 048-18-0925 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 95 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8-2-93 | 8. BIRTHPLACE (State or Foreign Country): NEW YORK |
| 9a. FACILITY NAME (If not institution, give street and number): KESWICK HOME 700 W. 40th St-21211 | | 9b. CITY, TOWN OR LOCATION OF DEATH: Balto. Md | | 9c. COUNTY OF DEATH: — |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: --- | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3838 Roland Avenue | | 10f. ZIP CODE: 21211 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: at Home | |
| 17. FATHER'S NAME (First, Middle, Last): EDWARD EITER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET MARY O'CONNOR | |
| 19a. INFORMANT'S NAME (Type/Print): Rob't. G. Loecher / Chrystal R. Ecklberg RN | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Keswick Home 7100 Bellona Ave.-21212 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/7/89 | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery "ELM" Lot 709 Grave 4 | 20c. LOCATION — City or Town, State: Balto. City, Md.-21234 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ George F. Sander, Jr. #M00503 | 22. NAME AND ADDRESS OF FACILITY: Henry Sander & Sons, Inc. 1649 E. North Ave., Balto., Md.-21213 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Parkinson's disease with dementia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M. Isabelle MacGregor MD | 29c. LICENSE NUMBER: D13657 | 29d. DATE SIGNED (Month, Day, Year): ▶ April 5, 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M. ISABELLE MacGREGOR, KESWICK, 700 W 40th Street, BALTO. MD 21211 | | |
| 31. DATE FILED (Month, Day, Year): APR 10 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11141
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/cremation permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): (BABY) Terri D. Lomax
**2. DATE OF DEATH** (Month, Day, Year): 4-10-89
**3. TIME OF DEATH**: 12:23PM M
**4. SOCIAL SECURITY NUMBER**: NA
**5. SEX**: 1 ☐ M 2 ☒ F
**6. AGE** (In yrs. last birthday): 0 YRS. — IF UNDER 1 YEAR: MONTHS 11 DAYS — IF UNDER 24 HRS.: HOURS MIN.
**7. DATE OF BIRTH** (Month, Day, Year): 5/14/88
**8. BIRTHPLACE** (State or Foreign Country): MD
**9a. FACILITY NAME** (If not institution, give street and number): Johns Hopkins Hospital
**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore City
**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD
**10b. COUNTY**:
**10c. CITY, TOWN OR LOCATION**: BALTIMORE
**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO
**10e. STREET AND NUMBER**: 1569 HOMESTEAD STREET
**10f. ZIP CODE**: 21218
**10g. CITIZEN OF WHAT COUNTRY?**: USA
**11. MARITAL STATUS**: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
**14. RACE — American Indian, Black, White, etc.** Specify: BLACK
**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): NA — College (1-4 or 5+):
**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): NA
**16b. KIND OF BUSINESS/INDUSTRY**: CHILD
**17. FATHER'S NAME** (First, Middle, Last): BERNARD DAVIS
**18. MOTHER'S NAME** (First, Middle, Maiden Surname): KIM LOMAX
**19a. INFORMANT'S NAME** (Type/Print): KIM LOMAX
**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1569 HOMESTEAD STREET?BALTO., MD 21218
**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): KING MEMORIAL PARK
**20c. LOCATION — City or Town, State**: RANDALLSTOWN, MD
**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Anthony E. Ward
**22. NAME AND ADDRESS OF FACILITY**: WILLIAM C. MARCH F/H 1101 E. NORTH AVENUE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.** — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Blunt injuries to head and extremities and Thermal
DUE TO (OR AS A CONSEQUENCE OF): XXXXXXXXXXXXXXXXX injuries to Right Hand

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☒ YES 2 ☐ NO
**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** ☒ YES 2 ☐ NO
**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☒ YES 2 ☐ NO
**26. PLACE OF DEATH** (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
**27. MANNER OF DEATH**: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
**28a. DATE OF INJURY** (Month, Day, Year): 4-8-89
**28b. TIME OF INJURY**: M
**28c. INJURY AT WORK?** 1 ☐ YES 2 ☒ NO
**28d. DESCRIBE HOW INJURY OCCURED**: Subject beaten/burn injury
**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify): home
**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State): 3324 Woodland Avenue
**29a. CERTIFIER** (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
**29b. SIGNATURE AND TITLE OF CERTIFIER**: Charles P. Kokes MD
**29c. LICENSE NUMBER**: OCME
**29d. DATE SIGNED** (Month, Day, Year): ▶ 4-11-89
**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Charles P. KOkes,M.D. 111 Penn Street,Baltimore,MD 21201 VC
**31. DATE FILED** (Month, Day, Year): APR 12 1989
**32. REGISTRAR'S SIGNATURE**: Barbara Randall

OHMH-16 Rev 1/89

89 11142

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Joseph LEWIS | | | 2. DATE OF DEATH (Month, Day, Year): 4 6 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 213-07-4248 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 77 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 5/15/1911 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): 145 N. Streeper St. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore City | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 145 N. Streeper St. | | 10f. ZIP CODE: 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Cauc. |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unk. College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Steelworker | | 16b. KIND OF BUSINESS/INDUSTRY: Steel |
| 17. FATHER'S NAME (First, Middle, Last): Leo H. Lewis | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret O'Brien | |
| 19a. INFORMANT'S NAME (Type/Print): Clara Lewis | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 145 N. Streeper St. Baltimore, Md. 21224 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Stanislaus Cem. | | 20c. LOCATION — City or Town, State: Baltimore, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Bernard Dabrowski Sr. | | 22. NAME AND ADDRESS OF FACILITY: B. Dabrowski & Son Funeral Home 2818 E. Baltimore St. 21224 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Mesothelioma | 2 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

a. colon cancer
b. arteriosclerotic cardiovascular disease
c. chronic obstructive pulmonary disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Chi-Shiang Chen | D 18151 | ▶ 4-7-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Chi-Shiang Chen, M.D.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| 4/7/89 APR 07 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11143

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| Robert | Lomack | 4--6--89 | 3:32PM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 5. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 139-24-4535 | 1 [X] M 2 [ ] F | 66 YRS. | | | 1 16 1923 | N.J. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Sinai Hospital | Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md | | Baltimore | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 5105 Litchfield Avenue | 21215 | U S A |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No--- If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [ ] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| N/A | Roseburd Moore |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Denise Johnson | 4025 Sinclair Lane Baltimore, Md 21213 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Mt Zion Cemetery | Lansdown, Md |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ [signature] | March F/H West 4300 Wabash Avenue |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO |
| INSPECTION | |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 5 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| [X] 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | OCME | ▶ 4-7-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201 vc

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| | APR 12 1989 [signature] |

DHMH-16 Rev 1/89

89 11173

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11144

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cramation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): FLORENCE E. LEHNER | | 2. DATE OF DEATH (Month, Day, Year): 4 / 10 / 89 | 3. TIME OF DEATH: 4:20 PM |
| 4. SOCIAL SECURITY NUMBER: 215-03-2856 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 1/3/13 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): SINAI Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: Balto. City | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Balto. City | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2211 ROGERS AVE. | 10f. ZIP CODE: 21209 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 8+): Unknown | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): Arthur Bowling | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Carr Richerson | |
| 19a. INFORMANT'S NAME (Type/Print): John Lehner | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2690 Shamrock Drive, Venice, Fla 34293 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | 20c. LOCATION — City or Town, State: Glen Burnie, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lyman Burgee Henss | | 22. NAME AND ADDRESS OF FACILITY: Burgee-Henss Funeral Home, 3631 Falls Road, Baltimore, Md 21211 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIOPULMONARY ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. SEPTIC SHOCK | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. PNEUMONIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CONGESTIVE HEART FAILURE

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mark Cua MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/10/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARK CUA, SINAI | | |
| 31. DATE FILED (Month, Day, Year): APR 13 1989 | 32. REGISTRAR'S SIGNATURE: [illegible] | |

DHMH-16 Rev 1/89

2032252
LAWS, DOROTHY M409521
DR SHER CAR
3620 REISTERSTOWN RD
3-31-89 MC

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11145
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOROTHY L. LAWS
2. DATE OF DEATH (Month / Day / Year): 4 / 4 / 89
3. TIME OF DEATH: 9:07 M
4. SOCIAL SECURITY NUMBER: 215162014
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 67 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2/19/22
8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): LMC LIBERTY MED. CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore city
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore city
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3620 Reisterstown Road
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? U. S. A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY: Hoopers Mill
17. FATHER'S NAME (First, Middle, Last): Spicer Laws
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sadie Forrester
19a. INFORMANT'S NAME (Type/Print): Mr. Ronald Laws
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3620 Reisterstown Road, Baltimore, Md. 21215
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK
20c. LOCATION — City or Town, State: BALTO. CO., MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vernon R. Bailey
22. NAME AND ADDRESS OF FACILITY: NUTTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac arrest | 4 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 3/31/89
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Jonnie D Roper M.D.
29c. LICENSE NUMBER: D 35881
29d. DATE SIGNED (Month, Day, Year): ▶ 4/4/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): APR 5 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 11146

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOHN J. LEONO | | | 2. DATE OF DEATH (Month, Day, Year): April 10, 1989 | 3. TIME OF DEATH: 1:45 P.M. |
| 4. SOCIAL SECURITY NUMBER: 216-12-7969 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 68 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 1-6-1921 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 805 Lenton Avenue Apartment A. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 805 Lenton Ave. Apt A | 10f. ZIP CODE: 21212 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Yrs. / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Guard | 16b. KIND OF BUSINESS/INDUSTRY: Detective Agency | |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Leono | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Agnes Schneider | | |
| 19a. INFORMANT'S NAME (Type/Print): Mary Leono | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 805 Lenton Ave.,Apt A., Balto., Md. 21212 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery 4-13-89 | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Roy H. Cather Roy H. Cather | 22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck, Inc. 5305 Harford Road 21214 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiac Arrest | None |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Severe Congestive Heart Failure | 2 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Arteriosclerotic Heart Disease | 10 years |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Robert W Peters MD | 29c. LICENSE NUMBER: D24566 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/11/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert W. Peters, M.D. Loch Raven Veteran's Hospital

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 11 1989 | 32. REGISTRAR'S SIGNATURE: Julia Taylor-Parker |

DHMH-16 Rev 1/89

89 11146

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11147

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Stanley Lesniewski STANISLAW LESNIEWSKI | | | 2. DATE OF DEATH (Month / Day / Year): 4 / 7 / 89 | 3. TIME OF DEATH: 9:08 M |
| 4. SOCIAL SECURITY NUMBER: 218-10-3320 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11-07-17 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): Deaton Hospital & Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE , CITY MARYLAND | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 268 S. DUNCAN STREET | | 10f. ZIP CODE: 21231 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 6TH GRADE; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER | 16b. KIND OF BUSINESS/INDUSTRY: BETH. STEEL | |
| 17. FATHER'S NAME (First, Middle, Last): ANTHONY LESNIEWSKI | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): JOSEPHINE MILECKI | |
| 19a. INFORMANT'S NAME (Type/Print): MR. STEPHEN LESNIEWSKI | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1219 SPRING AVENUE BALTO, MD. 21237 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SACRED HEART OF MARY CEM. | 20c. LOCATION — City or Town, State: BALTO. CO. MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond L. Kaczorowski | | 22. NAME AND ADDRESS OF FACILITY: KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD 21224 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Failure - | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Aspiration Pneumonia. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Brain Damage from Hypoxic Encephalopathy. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

(1) Diabetes Mellitus -
(2) Dementia -

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) Deaton Medical Center |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: L. Lesley M.D. | 29c. LICENSE NUMBER: D-27609 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-8-89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RUBEN REIDER M.D. 7445 FURNACE BRANCH Rd. Glen Burnie 21061 | | | |
| 31. DATE FILED (Month, Day, Year): APR 10 1989 | 32. REGISTRAR'S SIGNATURE: Judith Davidson-Randall | | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11148
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROSALIE LACEY | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 2 1989 | 3. TIME OF DEATH: 07:35 A M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 76 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 04710712 | 8. BIRTHPLACE (State or Foreign Country): New Jersey |
| 9a. FACILITY NAME (If not institution, give street and number): Church Home Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH | | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Baltimore | Owingsmills | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 123 Tollgate Road | 21117 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | 5+ | Libranian | Govt. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Edwin Dudley | Eleanor Harwood |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Marlaine Leonard | 123 Tollgate Road, Owingsmills, Maryland 21117 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Baltimore-Washington Crematory | Laural, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| [signature] | Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road, Arbutus, Md. |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Adult respiratory distress syndrome | 1 week |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. bilateral Pneumonia | 3 wks |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: renal failure

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) |
|---|---|
| 1 ☐ YEB 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] M.D | MD D24034 | 4/2/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Timothy J. Low, M.D. Church Hospital

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 4 1989 | [signature] Lucia Davidson-Randall |

DHMH-16 Rev 1/89

Item 7 per F.H.
4-89 cg

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11149

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROBERT MARABLE, JR. | | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 8, 1989 | 3. TIME OF DEATH: 9:56 P M |
| 4. SOCIAL SECURITY NUMBER: 216-18-6804 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 71 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 5/01/~~89~~ 17 | 8. BIRTHPLACE (State or Foreign Country): NC |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 282 S. DALLAS COURT | | | 10f. ZIP CODE: 21231 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BALTIMORE CITY | | 16b. KIND OF BUSINESS/INDUSTRY: RETIRED | |
| 17. FATHER'S NAME (First, Middle, Last): ROBERT MARABLE SR. | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ELLA | | |
| 19a. INFORMANT'S NAME (Type/Print): ROBERT MARABLE III | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 742 MELLO COURT BALTO. MD 21205 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): EASTVIEW MEMORIAL PARK | | 20c. LOCATION — City or Town, State: DUNDALK, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John B. Johnson Jr. | | 22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary Arrest | 10mn. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pulmonary Embolus | 48 hours. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. retro peritoneal bleed | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition
Alcohol Abuse
heparin Therapy

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | M | 1 [ ] YES 2 [ ] NO | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Gail Wurmser | D29423 | ▶ 4/9/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAYMOND T CHUNG MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 13 1989 | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11150
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Norman J Mentchler | | | 2. DATE OF DEATH: MONTH 4 DAY 26 YEAR 89 | 3. TIME OF DEATH: 9:05 PM |
| 4. SOCIAL SECURITY NUMBER: 175 22 8541 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 61 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3/13/28 | 8. BIRTHPLACE (State or Foreign Country): PA |
| 9a. FACILITY NAME (If not institution, give street and number): Local Daven Veterans Hosp | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, MD | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | | |
|---|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: ~~Baltimore~~ Anne Arundel | 10c. CITY, TOWN OR LOCATION: ~~Baltimore~~ Glen Burnie | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 339 GATEWATER CT Apt202 | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: Korea | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired): Maintenence | 16b. KIND OF BUSINESS/INDUSTRY: Factory | | |
| 17. FATHER'S NAME (First, Middle, Last): UnKnown | 18. MOTHER'S NAME (First, Middle, Maiden Surname): UnKnown | | | |
| 19a. INFORMANT'S NAME (Type/Print): Connie Kurtell | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 339 GATEwater CT. Glen Burnie 21061 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MD Veterans Cem. | 20c. LOCATION — City or Town, State: Crownsville, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: ROBERT S. BARRANCO SEVERNA PARK, MD. 21146 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Anominate Artery Blow-out | 35" |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pharyngeal, esophageal Cancer | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☒ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | — | ▶ 4/26/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert H Woods MD Johns Hopkins Hospital

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 03 1989 | Phillis Davidson-Randall |

OHMH-16 Rev 1/89

339 GATEWATER CT
GLEN BURNIE MD 21061

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): William L. Mullins | | | | 2. DATE OF DEATH (Month / Day / Year): 4 / 17 / 89 | 3. TIME OF DEATH: 10:30 PM M |
| 4. SOCIAL SECURITY NUMBER: 719-03-8577 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 83 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | | 7. DATE OF BIRTH (Month, Day, Year): 2/ /06 | 8. BIRTHPLACE (State or Foreign Country): West Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Villa St. Michael | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: ------ | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: ------ | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 3530 Hickory avenue | | 10f. ZIP CODE: 21211 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineer | | 16b. KIND OF BUSINESS/INDUSTRY: Railroad | |
| 17. FATHER'S NAME (First, Middle, Last): Mullins | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Fannie Hatfield | | | |
| 19a. INFORMANT'S NAME (Type/Print): Darlene Manning | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 535 Union Bridge, Maryland 21791 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify): Entombment | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Memorial | | 20c. LOCATION — City or Town, State: Cockeysville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: Burgee-Henss Funeral Home 3631 Falls Road Baltimore, MD 21211 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CEREBRAL THROMBOSIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE PULMONARY DISEASE; DEMENTIA

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Jasveen Saluja MD | D28595 | ▶ 4/19/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Harold Bob 7220 Park Heights Baltimore, Maryland 21215

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 25 1989 | Julia Davidson-Rondeau |

DHMH-18 Rev 1/89

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Items23a thu28f Per M.E. FilmG651 5/12/89 CG

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| DEBRA | MONTGOMERY | 4-22-89 | 2:00AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-84-4445 | 1 ☐ M 2 ☒ F | 27 YRS. | | | 4 22 62 | Baltimore, Md. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Liberty Medical Center | Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | | Baltimore | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1618 Westwood Ave. | 21217 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Unemployed | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Herbert Montgomery | Norma Sharps |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Herbert Montgomery | 1618 Westwood Ave. Balto. Md. 21216 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | AR Cutus Mem. Park 4-28-89 | Balto Co. Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Joseph L. Russ | Joseph L. Russ 2222 W. North Ave. Balto. Md. 21216 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute narcotic intoxication | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| ☒ YES 2 ☐ NO | ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☒ Could not be determined | unknown | M | 1 ☐ YES 2 ☒ NO | Unknown |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Unknown | Unknown |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Margarita Korell | OCME | ▶ 4-22-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

VC Margarita A. Korell, M.D. 111 Penn Street, Baltimore, MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 28 1989 | [signature] |

DHMH-16 Rev 1/89

88 11125

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11153
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Ellen MacDonald | | | | | 2. DATE OF DEATH: MONTH 4 DAY 23 YEAR 89 | 3. TIME OF DEATH: 0430 M |
| 4. SOCIAL SECURITY NUMBER: 218-38-4822 | 5. SEX: 2 [X] F | 6. AGE (In yrs. last birthday): 74 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Oct. 10 9 14 | 8. BIRTHPLACE (State or Foreign Country): PA. |
| 9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: -- | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: -- | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 116 N. Port St. | | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+): -- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dishwasher | 16b. KIND OF BUSINESS/INDUSTRY: Drug Store | |
| 17. FATHER'S NAME (First, Middle, Last): UNKNOWN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN | |
| 19a. INFORMANT'S NAME (Type/Print): Shirley Ajello - Daughter | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 116 N. Port St., Balto, Md. 21224 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus | 20c. LOCATION — City or Town, State: Balto, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dennis A Capetano | | 22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME, 3331 Brehms Lane 21213 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

CARDISPULMONARY ARREST

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST: b. Cerebrovascular event CEREBROVASCULAR EVENT | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/23/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): STEVEN M-GOTTLIEB MD / BR. M-TAQI CHURCH HOME & HOSPITAL | | DR. TAQI MOHAMMAD |
| 31. DATE FILED (Month, Day, Year): APR 25 1989 | 32. REGISTRAR'S SIGNATURE: Julia Dixon Parker | |

DNMN-t8 Rev 1/89

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89 11154

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): PERLYA MAGIDMAN | | | | | 2. DATE OF DEATH MONTH: 04 DAY: 15 YEAR: 1989 | | 3. TIME OF DEATH: 7:15 PM |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 67 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): AUG. 21, 1921 | | 8. BIRTHPLACE (State or Foreign Country): RUSSIA |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 5906 PARK HEIGHTS AVE. APT. 401 | | | 10f. ZIP CODE: 21215 | | | 10g. CITIZEN OF WHAT COUNTRY?: RUSSIA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | | | 16b. KIND OF BUSINESS/INDUSTRY: HOMEMAKER | | |
| 17. FATHER'S NAME (First, Middle, Last): AVRUM ZELTSER | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): IDA ZELTSER | | | | |
| 19a. INFORMANT'S NAME (Type/Print): MIRON MAGIDMAN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5906 PARK HEIGHTS AVE. APT. 401 Balto, Md. (21215) | | | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARLINGTON CEMETERY | | | 20c. LOCATION — City or Town, State: BALTO., MD. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jack H Levinson | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215) | | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. It must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiogenic shock | 6 hours |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Myocardial infarction | 18 hours |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Lewis Becker, M.D.

29c. LICENSE NUMBER: D00744

29d. DATE SIGNED (Month, Day, Year): ▶ 4/16/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LEWIS BECKER HALSTED 500 JOHNS HOPKINS HOSPITAL

31. DATE FILED (Month, Day, Year): APR 20 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Kinard

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**

# CERTIFICATE OF DEATH

REG. NO. 89 11155

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CONLY AKA Conley MAINOR Jr.
2. DATE OF DEATH: MONTH 4 DAY 17 YEAR 89
3. TIME OF DEATH: 5:29 AM
4. SOCIAL SECURITY NUMBER: 239-42-0383
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 59 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8-9-29
8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): 913 N. Carrollton Avenue-vacant
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 913 Carrollton Ave.
10f. ZIP CODE: 21217
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married (Sept) 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5 +)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.):
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Conley Mainor Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ada Fergeson
19a. INFORMANT'S NAME (Type/Print): Mrs. Louvera McCollum
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1534 Leslie St Balto. Md. 21217
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cem. 4-22-89
20c. LOCATION — City or Town, State: Balto. Co. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ
22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ 2222 W. North Ave. Balto. Md. 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease and diabetes mellitus

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: chronic alcohol abuse

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO — head and abdomen
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) vacant house
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one):
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] Russ F 10
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): 4-17-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James A. Kaplan, M.D. 111 Penn Street Baltimore, MD 21201
31. DATE FILED (Month, Day, Year): APR 18 1989
32. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

89 11155

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11156

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| Italia (Ida) | Manzo | April 20, 1989 | 10 20 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-14-8955 | 1 ☐ M 2 ☒ F | 73 YRS. | | | Jan. 21, 1916 | Italy |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 3720 Gough Street 21224 | Baltimore | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | | Baltimore, Maryland | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 3720 Gough Street | 21224 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5 +) | | |
| 12th | — | seamstress | F+F |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Michele Azzari | Luisa |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ernie M. Manzo | 2110 Windon Court, Balto, Md. 21014 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) b v | Sacred Heart of Jesus Cem. | Baltimore, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Joseph N Zannino Jr. | Joseph N. Zannino Jr. Funeral Home 263 S. Conkling Street 21224 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Aorta CVA | 8 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. generalized AS | Yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Diabetes mellitus | Yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D 10699 | ▶ 4/20/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
E. Lee Robbins MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 24 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11157 REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) FANNIE MARQUESS | | | | 2. DATE OF DEATH (Month, Day, Year) Apr 15, 1989 | 3. TIME OF DEATH 5 A. M |
| 4. SOCIAL SECURITY NUMBER 220-05-0486 | 5. SEX 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday) 72 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) MAY 27, 1916 | 8. BIRTHPLACE (State or Foreign Country) MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number) LEVINDALE AGED HOME | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE MARYLAND | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER 6518 EBERLE DR. , APT. 103 | | 10f. ZIP CODE 21215 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 8 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALES | 16b. KIND OF BUSINESS/INDUSTRY RETAIL | |
| 17. FATHER'S NAME (First, Middle, Last) GABRIEL YAFFE | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EDITH UNKNOWN | |
| 19a. INFORMANT'S NAME (Type/Print) MS. LINDA MARQUESS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9633 W. WINDOW WAY, COLUMBIA, MD 21046 | |
| 20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) AGUDAS ACHIM ANSHE SFARD | 20c. LOCATION — City or Town, State ROSEDALE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Jack H Levinson | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Atherosclerotic Coronary vascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Rheumatoid arthritis
Nephrotic syndrome

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER Joseph J. Gallo MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4-15-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOSEPH GALLO, LEVINDALE GERIATRIC CTR. BALTO. 21215 | | |
| 31. DATE FILED (Month, Day, Year) APR 20 1989 | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11158
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| BABY | MARSH | MARCH 17, 1989 | 5:48A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| | 1 ☐ M 2 ☒ F | YRS. | | | 03-17-89 | MARYLAND |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| THE JOHNS HOPKINS HOSPITAL | BALTIMORE CITY | BALTIMORE |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | SOMERSET | CRISTFIEDL | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 15 WALNUT ST. | 21817 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5 +) | | |
| | | | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| JORDAN, STEVEN | BRENDA MARSH |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| BRENDA MARSH | 15 WALNUT ST. CRISTFIELD, MARYLAND 21817 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | THE JOHNS HOPKINS HOSPITAL | BALTIMORE, MARYLAND |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Extreme Preenaturity | ½ hour |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Intra uterine maceration

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| | | | | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Terence R. Flotte | D36039 | ▶ 3/17/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Terence R. Flotte, M.D. Johns Hopkins Doctor's Lounge Baltimore MD 21205

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| | |

DHMH-16 Rev 1/89

88 11128

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11159
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): IRVIN M. MARSHALL | | | 2. DATE OF DEATH: MONTH 04 DAY 23 YEAR 89 | 3. TIME OF DEATH: 7:08 a M |
| 4. SOCIAL SECURITY NUMBER: 227-05-5990 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 02-29-12 | 8. BIRTHPLACE (State or Foreign Country): VIRGINIA |
| 9a. FACILITY NAME (If not institution, give street and number): V.A.MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: - |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: GLEN BURNIE | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 209 KENT ROAD | | 10f. ZIP CODE: 21061 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW 11 | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 06; College (1-4 or 8+): - | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PUMP GAUGER | 16b. KIND OF BUSINESS/INDUSTRY: OIL MANUFACTURING | | |
| 17. FATHER'S NAME (First, Middle, Last): RICHARD T. MARSHALL | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MAUDE BRISTOW | | |
| 19a. INFORMANT'S NAME (Type/Print): E.MAXINE MARSHALL | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 209 KENT ROAD GLEN BURNIE,MD. 21061 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GLEN HAVEN CEMETERY | 20c. LOCATION — City or Town, State: GLEN BURNIE,MD. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | 22. NAME AND ADDRESS OF FACILITY: RAYMOND C.FINK FUNERAL HOME 21061 426 CRAIN HWY.S.W.GLEN BURNIE,MD. | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pneumonia | 6 d. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Stage D Prostate cancer | 3 yrs ago |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Chronic Obstructive Pulmonary Disease | not available |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

~~COPD~~ Esophageal CA - 11 years ago - esoph. pull through surgery

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

25. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD

29c. LICENSE NUMBER: AV 4635427BF87

29d. DATE SIGNED (Month, Day, Year) ▶ 4/23/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3900 LOCH RAVEN BLVD, BALT. MD 21218

31. DATE FILED (Month, Day, Year): APR 26 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Lindsay

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11160
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Jennie (AKA Jenny) Marshall | | | 2. DATE OF DEATH (Month, Day, Year): 4-20-89 | 3. TIME OF DEATH: 3:15PM M |
| 4. SOCIAL SECURITY NUMBER: 216-07-1200 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. | 7. DATE OF BIRTH (Month, Day, Year): 2,11 1888 | 8. BIRTHPLACE (State or Foreign Country): va |
| 9a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2600 Liberty Avenue | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 5th grade — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: unknown |
| 17. FATHER'S NAME (First, Middle, Last): Marion Bomlett | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Leda Jones | |
| 19a. INFORMANT'S NAME (Type/Print): Edna Foster | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2727 Munn Ave 21213 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New 42589 | 20c. LOCATION — City or Town, State: Baltimore Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Alethia L. B. Grimes | 22. NAME AND ADDRESS OF FACILITY: Alethia L. B. Grimes Funeral Home Chapel 2302 Wilkens Ave | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hypertensive Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| ☒ YES 2 ☐ NO | ☒ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin | OCME | ▶ 4-21-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. — 111 Penn Street, Baltimore, MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 24 1989 | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11161
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Albert W. Mattern Jr. | | 2. DATE OF DEATH (Month, Day, Year): 04 / 21 / 89 | 3. TIME OF DEATH: 2:55 PM |
| 4. SOCIAL SECURITY NUMBER: 212-34-4482 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 50 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7/6/38 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: Baltimore City | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 213 Werner Road | 10f. ZIP CODE: 21226 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic | 16b. KIND OF BUSINESS/INDUSTRY: Automobile | |
| 17. FATHER'S NAME (First, Middle, Last): Albert W. Mattern Sr. | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Naomi M. Taylor | | |
| 19a. INFORMANT'S NAME (Type/Print): Lillian M. Mattern | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 213 Werner Road, Baltimore, Maryland 21226 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | 20c. LOCATION — City or Town, State: Glen Burnie, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard E Davis | 22. NAME AND ADDRESS OF FACILITY: George J. Gonce Funeral Home 4001 Ritchie Hgwy Balto, Md 21225 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Myocardial Infarction | 3hrs |
| DUE TO (OR AS A CONSEQUENCE OF): | b. Hypertension Atherosclerotic Cardiovascular Dis | 5yrs. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 5 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Michael J Gormley MD | 29c. LICENSE NUMBER: D21703 | 29d. DATE SIGNED (Month, Day, Year): 4/21/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M.F. Gormley MD 865 E. Ft. Smallwood Rd. Pasadena Md 21122

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11162
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RAYMOND FRANCIS MCCLEARY | | | 2. DATE OF DEATH (Month, Day, Year): 4 12 89 | 3. TIME OF DEATH: 11:40P M |
| 4. SOCIAL SECURITY NUMBER: 016-10-1777 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9/10/08 | 8. BIRTHPLACE (State or Foreign Country): Mass. |
| 9a. FACILITY NAME (If not institution, give street and number): Levindale Home | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Catonsville | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 839 Hilltop Road | 10f. ZIP CODE: 21228 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] ND Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager | 16b. KIND OF BUSINESS/INDUSTRY: Westinghouse | |
| 17. FATHER'S NAME (First, Middle, Last): Frank McCleary | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Moriority | |
| 19a. INFORMANT'S NAME (Type/Print): Margaret E. McCleary | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 839 Hilltop Road Baltimore, Maryland 21228 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Security Process Crematory | 20c. LOCATION — City or Town, State: Catonsville, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jackie M. Shannon | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ASPIRATION PNEUMONIA | 1 WEEK |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DYSPHAGIA DUE TO (OR AS A CONSEQUENCE OF): | YEARS |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE PULMONARY DISEASE

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO N/A | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): — | 28b. TIME OF INJURY: — M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: — | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): — | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): — |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D 30951 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-13-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. J. LUCCA MD 7434 W BELVEDERE AVE BALTO 21215 | | |
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | 32. REGISTRAR'S SIGNATURE: [signature] | |

DHMH-16 Rev 1/89

89 11163

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): LEWIS MCCORMICK — Lewis Irving Mc Cormick
2. DATE OF DEATH: MONTH 4 DAY 18 YEAR 89
3. TIME OF DEATH: 820 A M
4. SOCIAL SECURITY NUMBER: 216-1009095
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 06-13-08
8. BIRTHPLACE (State or Foreign Country): Va.
9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: City

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Eastwood
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 7052 Eastbrook Avenue
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: W.W. 2
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Car Man
16b. KIND OF BUSINESS/INDUSTRY: B & O C & O Railroad
17. FATHER'S NAME (First, Middle, Last): Duffer
18. MOTHER'S NAME (First, Middle, Maiden Surname):
19a. INFORMANT'S NAME (Type/Print): Mary Nellie Mc Cormick
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7052 Eastbrook Avenue Balto., Md. 21224
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery
20c. LOCATION — City or Town, State: Eastwood, Balto. Co., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles D. Zeiler
22. NAME AND ADDRESS OF FACILITY: Charles S. Zeiler & Son Inc 6224 Eastern Ave.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Laryngeal Ca
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Anoxic brain injury
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Intern @ the GSH
29c. LICENSE NUMBER: D 38118
29d. DATE SIGNED (Month, Day, Year): ▶ 4/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): XENOPOULOS NICHOLAOS GSH 5601 Loch Raven Blvd Balt. MD 21239
31. DATE FILED (Month, Day, Year): APR 18 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

89 1163

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11164
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): McCRAW, JOHN Henry
2. DATE OF DEATH: MONTH 04 DAY 18 YEAR 89
3. TIME OF DEATH: 9:05 P M
4. SOCIAL SECURITY NUMBER: [redacted] 216 42 5980
5. SEX: 1 X M 2 ☐ F
6. AGE (In yrs. last birthday): 44 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 3/16/45
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALT
9c. COUNTY OF DEATH: BALT

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: BALT
10c. CITY, TOWN OR LOCATION: BALT
10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 4113 ROCKFIELD AVE
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0-8; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED
16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): JOHN MC CRAW
18. MOTHER'S NAME (First, Middle, Maiden Surname): ALEASE IRBY

19a. INFORMANT'S NAME (Type/Print): MRS. VIOLA HAWKINS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5121 NELSON AVENUE BALTIMORE, MARYLAND 21215

20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTERN STAR CEMETERY 4/22/89
20c. LOCATION — City or Town, State: BALTIMORE (BALTO. CO.) MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lewis T. Gwynn
22. NAME AND ADDRESS OF FACILITY: LEWIS T. GWYNN FUNERAL HOME 21215 -6393, 4517 PARK HEIGHTS AVENUE BALTIMORE, MD.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CARDIAC INSUFFICIENCY / HYPOTENSION | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | AORTIC VALVE RUPTURE | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | BACTERIAL ENDOCARDITIS | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | IVDA | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HIV(+)

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: ASIN 23 — 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: S X MD
29c. LICENSE NUMBER: 9459
29d. DATE SIGNED (Month, Day, Year): ▶ 4/18/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHERYL TAYLOR SINAI HOSP, BALT

31. DATE FILED (Month, Day, Year): APR 20 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

Item:12 per FH G-650 4-25-89 WH
Item#6 Per F.H. FilmG651 5/22/89 CG

89 11165

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WILLIAM H. MCGEE JR. | | | 2. DATE OF DEATH: MONTH 04 DAY 18 YEAR 1989 | 3. TIME OF DEATH: 1:40 AM M |
| 4. SOCIAL SECURITY NUMBER: 218-40-5761 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): ~~56~~ 46 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year): 4/14/43 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: MONTGOMERY CO. | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 18223 MULBERRY COURT | | 10f. ZIP CODE: 20877 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ~~☒~~ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CONTEL | 16b. KIND OF BUSINESS/INDUSTRY: DATA ENTRY OPERATOR |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM H. McGEE SR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): JULIA ARMSTRONG | |
| 19a. INFORMANT'S NAME (Type/Print): CAROL McGEE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18223 MULBERRY COURT/ MONTGOMERY CO., MD 20877 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LANES CHURCH CEMETERY | 20c. LOCATION — City or Town, State: TAYLORS ISLAND, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard Landeck | | 22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. sepsis | 1 week |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. disseminated intravascular coagulation | 1 week |
| | DUE TO (OR AS A CONSEQUENCE OF): c. liver failure | 4 months |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: renal failure, adult respiratory distress syndrome

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Thea Nichols MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thea Nichols MD Johns Hopkins Hospital → 4/18/89 | | |
| 31. DATE FILED (Month, Day, Year): APR 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Pendergast-Landeck | |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 11166

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Eleanor N. Meeker
2. DATE OF DEATH: Month 4 Day 15 Year 89
3. TIME OF DEATH: 2050 M
4. SOCIAL SECURITY NUMBER: 216-46-5060
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 77 YRS. | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN.
7. DATE OF BIRTH (Month, Day, Year): 8/25/11
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Church Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 101 North Bond Street
10f. ZIP CODE: 21231
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER
16b. KIND OF BUSINESS/INDUSTRY: OWN HOME
17. FATHER'S NAME (First, Middle, Last): NEWTON NICHOLAS
18. MOTHER'S NAME (First, Middle, Maiden Surname): ELLA KUHNS
19a. INFORMANT'S NAME (Type/Print): JAMES W. GOLDEN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1208 LAKE FALLS RD. BALTO.MD.21210
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GREEN MT. CREMATORY
20c. LOCATION — City or Town, State: BALTO MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edison M. Perkins Jr.
22. NAME AND ADDRESS OF FACILITY: HENRY W. JENKINS AND SONS 4905 YORK RD. BALTO.MD.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer's Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Barbara Socha, M.D.
29c. LICENSE NUMBER: D35609
29d. DATE SIGNED (Month, Day, Year): ▶ 4/15/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BARBARA SOCHA 100 N. BROADWAY, BALTIMORE, MD 21231
31. DATE FILED (Month, Day, Year): APR 18 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 11166

89 11167

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James L. Meeks
2. DATE OF DEATH — MONTH: 4 DAY: 14 YEAR: 89
3. TIME OF DEATH: 0230 A M
4. SOCIAL SECURITY NUMBER: 215 52 4361
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): ~~59~~ 40 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4/5/49
8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): Mercy Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

**RESIDENCE OF DECEDENT**

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 8 W. Madison ST
10f. ZIP CODE: 21201
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cab driver
16b. KIND OF BUSINESS/INDUSTRY: Cab company
17. FATHER'S NAME (First, Middle, Last): THURMAN DAWES
18. MOTHER'S NAME (First, Middle, Maiden Surname): LYDIA MEEKS
19a. INFORMANT'S NAME (Type/Print): MARIE DAWES
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1312 STONEWOOD RD BALTIMORE MD 21239
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetary, crematory or other place):
20c. LOCATION — City or Town, State: BALTO, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: 2222 W. North Ave.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Pneumocystis pneumonia | 10 days |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Cardiopulmonary insufficiency | 10 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | acquired immune deficiency syndrome | unkwn |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: T Rebori M.D.
29c. LICENSE NUMBER: D22645
29d. DATE SIGNED (Month, Day, Year): 4/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas A. Rebori 301 St. Paul Place Baltimore MD
31. DATE FILED (Month, Day, Year): APR 18 1989
32. REGISTRAR'S SIGNATURE: Juha Davidson-Rendell

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11168
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARY LORRAINE MEGENHARDT | | | 2. DATE OF DEATH (Month, Day, Year): 4/18/89 | 3. TIME OF DEATH: 3:10A.M. M |
| 4. SOCIAL SECURITY NUMBER: 217-24-9987 | 5. SEX: ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3/6/19 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1413 Houghton Road | | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 8+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Harry Weippert | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Roberta Morrow | |
| 19a. INFORMANT'S NAME (Type/Print): Ray Magenhardt | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1413 Houghton Road Glen Burnie, Md. 21061 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Teresa Goff | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory & cardiac arrest | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): RENAL FAILER | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): SEPSIS CHF | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): CHF. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] Attn | 91412 | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 4/18/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sinai Hosp. Baltimore, maryland

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11169

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page ___ must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Lillie Mershon | | | 4 / 6 / 89 | 0641am M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218012162 | 1 ☐ M 2 ☒ F | 73 YRS. | | | 6/15/15 | |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| St. Agnes Hospital | Baltimore | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD. | | BALTIMORE | 1 ☐ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 39 OAKLEE VILLAGE | 21229 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| | |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| | |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) | | |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Donald Walker | STATE ANATOMY BOARD, BALTO., MD. 21201 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. BILATERAL PNEUMONIA.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Joseph Quist MD RESIDENT | | ▶ 4/6/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JOSEPH QUIST MD. ST AGNES HOSP. 900 CATON AVE. BALTO MD 21227

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 12 1989 | Linda Davidson-Rudasill |

DNMH-16 Rev 1/89

83 1126

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11170
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and [illegible] be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Bertram C. H. Meyers | | 2. DATE OF DEATH: MONTH 4 DAY 3 YEAR 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 212-05-5929 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10/17/07 |
| 8. BIRTHPLACE (State or Foreign Country): Md. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 616 Winans Way (home) | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 616 Winans Way | 10f. ZIP CODE: 21229 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): electrical engineer | 16b. KIND OF BUSINESS/INDUSTRY: BG &E |
| 17. FATHER'S NAME (First, Middle, Last): Thomas F. Meyers | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Katharine Miller | |
| 19a. INFORMANT'S NAME (Type/Print): Mary E. Meyers | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 616 Winans Way/Baltimore, MD 21229 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest | 20c. LOCATION — City or Town, State: Baltimore, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Peter S. Ashton Moore II | 22. NAME AND ADDRESS OF FACILITY: Sterling Ashton Funeral Estate 736 Edmondson Ave/Baltimore MD 21228 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. BRAIN TUMOR - PRIMARY | 6 mo. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Walter J. Alt, MD | 29c. LICENSE NUMBER: D20646 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WALTER J. ALT, M.D. 361 MARYDELL RD, BALTIMORE, MD 21229

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 4 1989 | 32. REGISTRAR'S SIGNATURE: Julia Kniderson-Randall |

OHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11171

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): James Leroy Middleton

**2. DATE OF DEATH** (Month, Day, Year): 4-11-89

**3. TIME OF DEATH**: 6:25PM M

**4. SOCIAL SECURITY NUMBER**: 215-09-7190

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 87 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 1/23/02

**8. BIRTHPLACE** (State or Foreign Country): Maryland

**9a. FACILITY NAME** (If not institution, give street and number): 3383 Dulany Street

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore City

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 [X] YES 2 [ ] NO

**10e. STREET AND NUMBER**: 3383 Dulany Street

**10f. ZIP CODE**: 21229

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 6th Grade
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Crain Operator

**16b. KIND OF BUSINESS/INDUSTRY**: Md. Drydock

**17. FATHER'S NAME** (First, Middle, Last): James Walter Middleton

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Isabelle

**19a. INFORMANT'S NAME** (Type/Print): Sandra L. Schriver

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3366 Dulany Street Baltimore, Md. 21229

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Loudon Park Cemetery

**20c. LOCATION — City or Town, State**: Baltimore, Maryland

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ M. Neal Coleman

**22. NAME AND ADDRESS OF FACILITY**: Hubbard Funeral Home, Inc.
4107 Wilkens Avenue Baltimore, Md. 21229

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

**IMMEDIATE CAUSE (Final disease or condition resulting in death)** →
a. Arteriosclerotic cardiovascular disease
DUE TO (OR AS A CONSEQUENCE OF):

**Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST**
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [X] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [X] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [ ] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Mario F. Golle Jr. MD

**29c. LICENSE NUMBER**: OCME

**29d. DATE SIGNED** (Month, Day, Year): ▶ 4-12-89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Mario F. Golle,Jr.,M.D. 111 Penn Street,Baltimore,MD 21201 vc

**31. DATE FILED** (Month, Day, Year): APR 20 1989

**32. REGISTRAR'S SIGNATURE**: Barbara Randall

DHMH-16 Rev 1/89

89 11171

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89-11172

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Timothy | Wayne | Miller | 4-18-89 | 7:00AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 198-42-6797 | 1 [X] M 2 [ ] F | 23 YRS. | | | Oct. 23, 1965 | Penna. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| I-83 N. of Shawn Road | Baltimore County | Baltimore Co. |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Penna. | York | Fawn Grove, Fawn Township | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| R.D.#1, Box 364 | 17321 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | Carpenter | Construction |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Everett Norman Miller | Peggy Marlene Walter |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Everett N. Miller | R.D.#1, Box 364, Fawn Grove, Pa. 17321 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Mt. Olivet United Meth. Cem. | Fawn Grove, Pa. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Richard S. Mitchell | Hartenstein-Orsburn Funeral Home 19 S. Main St., Stewartstown, Pa. 17363 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple injuries | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| [X] YES 2 [ ] NO | [X] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) scene |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 4-18-89 | 6:08AM | 1 [ ] YES 2 [X] NO | Driver in auto/tractor trailer impact |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| road | I-83/N. of Shawn Road Baltimore Co. |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Charles P. Kokes MD | OCME | ▶ 4-18-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Charles P. Kokes, M.D. 111 Penn Street, Baltimore, MD 21201 vc

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 24 1989 | Julia Davidson-Trendell |

OHMH-16 Rev 1/89

89 11173

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): WARDEN HAMILTON MILLER

**2. DATE OF DEATH** (Month, Day, Year): 04 / 11 / 1989

**3. TIME OF DEATH**: 1055 A M

**4. SOCIAL SECURITY NUMBER**: 236-14-2953

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 76 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 10/12/12

**8. BIRTHPLACE** (State or Foreign Country): West Virginia

**9a. FACILITY NAME** (If not institution, give street and number): Bon Secours Hospital

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore City

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 [X] YES 2 [ ] NO

**10e. STREET AND NUMBER**: 1702 Lemmon Street

**10f. ZIP CODE**: 21223

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade — College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Riveter

**16b. KIND OF BUSINESS/INDUSTRY**: Ship Building

**17. FATHER'S NAME** (First, Middle, Last): William Miller

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Ollie Earl

**19a. INFORMANT'S NAME** (Type/Print): Agnes Miller

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1702 Lemmon Street Baltimore, Maryland 21223

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Cedar Hill Cemetery

**20c. LOCATION — City or Town, State**: Brooklyn Pk., Maryland

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**:

**22. NAME AND ADDRESS OF FACILITY**: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis 2° Bilateral pneumonitis

DUE TO (OR AS A CONSEQUENCE OF): b. Metabolic Encephalopathy 2° #1

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c. Recurrent Seizure disorder

DUE TO (OR AS A CONSEQUENCE OF): d. Severe Chronic Obstructive pulmonary Disease

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

Old (L) Stroke with contractures of knees/arms
Old (R) Subdural Hematoma

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [X] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [ ] NO

**26. PLACE OF DEATH** (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: M.D.

**29c. LICENSE NUMBER**: D18711

**29d. DATE SIGNED** (Month, Day, Year): ▶ April 11 89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): BERNARDO D. GONZALES JR M.D. — Bon Secours Hospital 2000 W. Baltimore St. Md. 21223

**31. DATE FILED** (Month, Day, Year): APR 20 1989

**32. REGISTRAR'S SIGNATURE**:

DHMH-16 Rev 1/89

89 11173

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11174 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EVELYN ANNA MONAHAN / EVELYN ANNA MONAHAN
2. DATE OF DEATH (Month, Day, Year): 4/15/89
3. TIME OF DEATH: 10:11 PM
4. SOCIAL SECURITY NUMBER: 212-03-0878
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1/11/15
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTO.
9c. COUNTY OF DEATH: --

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: CATONSVILLE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2005 FERNGLEN WAY
10f. ZIP CODE: 21228
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): 3
15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LEGAL SECRETARY
16b. KIND OF BUSINESS/INDUSTRY: LAW
17. FATHER'S NAME (First, Middle, Last): HARRY D. FORD
18. MOTHER'S NAME (First, Middle, Maiden Surname): ELEANOR HORNEY
19a. INFORMANT'S NAME (Type/Print): R.KENT MONAHAN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18 KIMBALL RIDGE COURT, CATONSVILLE, MARYLAND 21228
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WOODLAWN CEMETERY
20c. LOCATION — City or Town, State: WOODLAWN, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES, 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CEREBRO VASCULAN ACCIDENT right
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. FRONTAL - TEMPORAL AREA
DUE TO (OR AS A CONSEQUENCE OF):
c. LEFT INTERTROCANTENIC FRACTURE
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PERIFERNOVASCULAN DISEASE
HIGH BLOOD PRESSURE
NON INSULIN DEPENDENT DIABETES

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
28. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 4/3/89
28b. TIME OF INJURY: -- M
28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 2005 FERNGLEN ST BALTO MD

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] President
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] ST AGNES HOSPITAL BALTIMORE MD
31. DATE FILED (Month, Day, Year): 4/15/89 APR 24 1989
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-18 Rev 1/89

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MOORE, ADAM
04/18/89 M

89 11175

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ADAM Joseph Moore | | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 30, 1989 | 3. TIME OF DEATH: 11:06 A M |
| 4. SOCIAL SECURITY NUMBER: (unknown) | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): YRS. | IF UNDER 1 YEAR: MONTHS / DAYS: 12 — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 4--18--89 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: ~~BALTIMORE~~ |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Pasadena | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 38 Nicholson Drive | | 10f. ZIP CODE: 21122 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): None; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Walter L. Moore Jr. | | 16. MOTHER'S NAME (First, Middle, Maiden Surname): Kelly G. Bollino | |
| 19a. INFORMANT'S NAME (Type/Print): Walter Moore Jr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 38 Nicholson Drive Pasadena, Maryland 21122 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Memorial Cemetery | 20c. LOCATION — City or Town, State: Annapolis, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jerome Freimuth | | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Asystole | 10 min |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. | Congenital heart defects | 2 weeks |
| DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURED |
| | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Peter Hornetter M.D. D30446 | 29c. LICENSE NUMBER: D30446 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/30/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): P. HORNETTER JOHNS HOPKINS HOSP. BALTO Md. | | |
| 31. DATE FILED (Month, Day, Year): MAY 3 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Kinlaw | |

DHMH-16 Rev 1/89

89 11175

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11176
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2/3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MORGAN, Alean | | | 2. DATE OF DEATH (Month, Day, Year): 04-17-89 | 3. TIME OF DEATH: 1:15 PM |
| 4. SOCIAL SECURITY NUMBER: 220-22-9959 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5/20/20 | 8. BIRTHPLACE (State or Foreign Country) |
| 9a. FACILITY NAME (If not institution, give street and number): 114 S. CATHERINE ST. | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, | | 9c. COUNTY OF DEATH: BALTO. CITY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE CITY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 114 S. CATHERINE ST. | | 10f. ZIP CODE: 21223 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RETIRED | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): TRUSS OWENS | 18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN |
| 19a. INFORMANT'S NAME (Type/Print): ALEAN NELSON | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 114 S. CATHERINE ST. (21223) |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Mem. Pk | 20c. LOCATION — City or Town, State: BALTO., MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lynette K. Jones | 22. NAME AND ADDRESS OF FACILITY: Brown-Thompson F.H. P.O. Box 4433 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. End Stage Renal Failure | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): Diabetes mellitus | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): Hypertensive arteriosclerotic | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): Heart Disease | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: multiple stroke with Dementia

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Home |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature], MD | 29c. LICENSE NUMBER: D16263 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/17/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): 1940 W. BALTIMORE ST, BALTIMORE, MD 21223

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 18 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rodgers |

DHMH-16 Rev 1/89

89 11175

Item#6 Per F.H. 4/25/89 CG

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11177

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARY MORTON | | | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 13, 1989 | 3. TIME OF DEATH: 7:15 A M |
| 4. SOCIAL SECURITY NUMBER: 215-24-2205B | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): ~~01~~ 80 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9/01/1908 | 8. BIRTHPLACE (State or Foreign Country): VIRGINIA |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 3038 GWYNNS FALLS PARKWAY | | 10f. ZIP CODE: 21216 | | | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | | | 16b. KIND OF BUSINESS/INDUSTRY: HOME | |
| 17. FATHER'S NAME (First, Middle, Last): JAMES PIERCE | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNIE BLANCHE WEST | |
| 19a. INFORMANT'S NAME (Type/Print): MR. LAWRENCE MORTON, SR. | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3038 GWYNNS FALLS PARKWAY, BALTIMORE, MD. 21216 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOUNT CALVARY CEMETERY | | 20c. LOCATION — City or Town, State: ANNE ARUNDEL CO., MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Herbert E. Nutter | | | 22. NAME AND ADDRESS OF FACILITY: NUTTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216 | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis | 24 hr |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Enterocolitis | 24 hr |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Renal failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Daniel W. Crist MD

29c. LICENSE NUMBER: D36943

29d. DATE SIGNED (Month, Day, Year): 4/13/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): 4/13/89 APR 21 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Landers

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 23 is marked, or item 25 should ably, injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11178

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Ellen ELLEN PEPPLER MUELLER Mueller | | 2. DATE OF DEATH: MONTH 04 DAY 17 YEAR 89 | 3. TIME OF DEATH: 10:38 P M |
| 4. SOCIAL SECURITY NUMBER: 212074458 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 75 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year): 05 09-13 |
| 8. BIRTHPLACE (State or Foreign Country) | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital Mercy Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore Baltimore | 9c. COUNTY OF DEATH: ----- | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Towson | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO |
| 10e. STREET AND NUMBER: 8410 Charles Valley Ct. | 10f. ZIP CODE: 21204 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE White |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: -------- |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Caryl L. Peppler | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Nora McAndrews |
| 19a. INFORMANT'S NAME (Type/Print): H. Anthony Mueller | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8410 Charles Valley Ct. Towson, Md. 21204 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Maria Cemetery | 20c. LOCATION — City or Town, State: Towson, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis Stephen Kenaka | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld 6500 York Rd. 21212 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic carcinoma of gallbladder | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Cairy A Packard MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 04-17-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 24 1989 | 32. REGISTRAR'S SIGNATURE: Julia Frieden Parker |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11179

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Walter J. Mugerson | | | 2. DATE OF DEATH (Month / Day / Year): 4 / 10 / 89 | 3. TIME OF DEATH: 1400 M |
| 4. SOCIAL SECURITY NUMBER: 259-09-3808 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 71 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 10/31/17 | 8. BIRTHPLACE (State or Foreign Country): Ga |
| 9a. FACILITY NAME (If not institution, give street and number): St Agnes Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3227 Leeds St | | 10f. ZIP CODE: 21229 | 10g. CITIZEN OF WHAT COUNTRY? |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) |
| | | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Phillip Mugerson | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Adel Adams |
| 19a. INFORMANT'S NAME (Type/Print): James A. Dixon | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3708 Old Millford Mill Road Balto Md 21207 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dale March | 22. NAME AND ADDRESS OF FACILITY: 4300 Wabash Ave. March F/H | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardio-Pulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Esophageal CA
DUE TO (OR AS A CONSEQUENCE OF):
c. GI bleeding
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: CKKim, Resident | 29c. LICENSE NUMBER: AS2438528 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/10/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Choong R. Kim, MD. St. Agnes Hosp. 900 Caton Ave Bal MD 21229

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 14 1989 | 32. REGISTRAR'S SIGNATURE: Madison Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11180

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): THERESA MURPHY. | | | 2. DATE OF DEATH (Month, Day, Year): 04 10 89 | 3. TIME OF DEATH: 5:00 AM |
| 4. SOCIAL SECURITY NUMBER: 220-30-5820 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 08-12-04 | 8. BIRTHPLACE (State or Foreign Country): NC |
| 9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTRE | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE. | | 9c. COUNTY OF DEATH: — |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1722 N. Fulton Ave | | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 6+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): John Smith | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Shipman |
| 19a. INFORMANT'S NAME (Type/Print): Ella R. Preston | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5108 Pembridge Ave Balto, Md 21215 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Mem Park | 20c. LOCATION — City or Town, State: Arbutus, Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ella March | 22. NAME AND ADDRESS OF FACILITY: 4300 Wabash Ave. Mary Hill | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ACUTE CEREBRO-VASCULAR ACCIDENT

DUE TO (OR AS A CONSEQUENCE OF):
b. ARTERIO-SCLEROTIC HEART DISEASE.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): —
c.

DUE TO (OR AS A CONSEQUENCE OF): —
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
- DIABETES MELLITUS
- RENAL INSUFFICIENCY.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED: — | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): — | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): — |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M.D. | 29c. LICENSE NUMBER: D 23300 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-10-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LIBERTY MEDICAL CENTRE
SUDHIR D. PATEL — 2600 Liberty Rd. Balto MD. 21215.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 14 1989 | 32. REGISTRAR'S SIGNATURE: Madison-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-11181

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be completed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it must be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Hooshang Malek

**2. DATE OF DEATH** (Month, Day, Year): April 19 1989

**3. TIME OF DEATH**: 6:30 AM

**4. SOCIAL SECURITY NUMBER**: 577-54-2953

**5. SEX**: 1 ☑ M 2 ☐ F

**6. AGE** (In yrs. last birthday): 61 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 3-21-1928

**8. BIRTHPLACE** (State or Foreign Country): Iran

**9a. FACILITY NAME** (If not institution, give street and number): Sinai Rehabilitation Hospital

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore

**9c. COUNTY OF DEATH**: Baltimore

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: Baltimore

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 3028 Essex Road

**10f. ZIP CODE**: 21207

**10g. CITIZEN OF WHAT COUNTRY?**: United States

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: Caucasian

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 years
College (1-4 or 5+): 2 years

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Electrical Engineer

**16b. KIND OF BUSINESS/INDUSTRY**: Hearing Aids

**17. FATHER'S NAME** (First, Middle, Last): Hassan Malek

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Tooba Khosrovi

**19a. INFORMANT'S NAME** (Type/Print): Katherina Malek (Wife)

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as # 10

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): George Washington Cemetery

**20c. LOCATION — City or Town, State**: Adelphi, Maryland

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Donald V. Borgwardt

**22. NAME AND ADDRESS OF FACILITY**: Borgwardt Funeral Home, 4400 Powder Mill Rd. Beltsville, Md. 20705

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ee cardiec or respiretory erreat, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a. (Possible) Pulmonary Emabolus

DUE TO (OR AS A CONSEQUENCE OF):

Sequantielly liet conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. (Possible) Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus — Recurrent Fevers/Infection
Cerebrovascular Disease
Hypertension

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☒ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Kenneth [illegible] M.D.

**29c. LICENSE NUMBER**: D34317

**29d. DATE SIGNED** (Month, Day, Year): 4/19/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): 2929 Guilford Ave. Baltimore, Md. 21218

**31. DATE FILED** (Month, Day, Year): APR 24 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11182

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained for your attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Use as the burial-transit permit. Pages 1, 2, 3 should
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JAMES MORRIS | | | 2. DATE OF DEATH (Month, Day, Year): MAY 2, 1989 | 3. TIME OF DEATH: 1:20 M |
| 4. SOCIAL SECURITY NUMBER: 215-24-9643 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4 9 29 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): BON SECOURS HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |

| | | |
|---|---|---|
| 10e. STREET AND NUMBER: 712 CUMBERLAND ST. | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY?: US |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married XX Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES XX NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ROOFER | 16b. KIND OF BUSINESS/INDUSTRY: |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): CLARENCE MORRIS | 18. MOTHER'S NAME (First, Middle, Maiden Surname): FRANCES WILLIAMS |

| | |
|---|---|
| 19a. INFORMANT'S NAME (Type/Print): MARIE MORRIS | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 712 CUMBERLAND ST. BALTIMORE, MD. 21217 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTVIEW MEM. PARK | 20c. LOCATION — City or Town, State: BALTIMORE, MD. |

| | |
|---|---|
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Marietta Keeta #281 | 22. NAME AND ADDRESS OF FACILITY: E.L. PHILLIPS 1721 N. MONROE ST. 21217 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MASSIVE BLEEDING

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. TERMINAL CANCER OF PHARYNX

DUE TO (OR AS A CONSEQUENCE OF):

c. AND NECK

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 28d. DESCRIBE HOW INJURY OCCURED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M.D. | 29c. LICENSE NUMBER: D18711 | 29d. DATE SIGNED (Month, Day, Year): ▶ May 2 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BERNARDO D. GONZALES JR MD. — Bon Secours Hospital 2000 W. Baltimore St. md. 21223

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 8 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

2

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11183
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital [illegible]

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for [illegible] transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WILLIAM J MCCARTHY, Sr. | | | 2. DATE OF DEATH (Month, Day, Year): April 30, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 143-28-5032 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11/3/37 | 8. BIRTHPLACE (State or Foreign Country): PA |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Md | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore City | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 401 Kensington Road | | 10f. ZIP CODE: 21229 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Director | | 16b. KIND OF BUSINESS/INDUSTRY: Social Security |
| 17. FATHER'S NAME (First, Middle, Last): Daniel J. McCarthy | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Nagle | | |
| 19a. INFORMANT'S NAME (Type/Print): Marie McCarthy | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 401 Kensington Road Balto, Md. 21229 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral | | 20c. LOCATION — City or Town, State: Baltimore, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: Sterling Ashton Funeral Estate, P.A. 736 Edmondson Avenue Balto 21228 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Possible arrythmia | hours |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Hypertensive cardiovascular disease | years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [X] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Steven H. [illegible] M.D. | D30206 | ▶ 5/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STEVEN H. PEARLMAN, M.D.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 8 _ 1989 | Julia Davidson-Gandee |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11184
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARGARET ELIZABETH MERKLE | | | 2. DATE OF DEATH (Month, Day, Year): 4 30 89 | 3. TIME OF DEATH: 7:30A M |
| 4. SOCIAL SECURITY NUMBER: 212-05-6328 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 1/28/05 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Catonsville | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 608 Southmont Road | | 10f. ZIP CODE: 21228 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): Daniel Kelleher | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ella Jane Trimmer | | |
| 19a. INFORMANT'S NAME (Type/Print): Joan E. Schwartz | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 608 Southmont Road Catonsville, Md. 21228 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CONGESTIVE HEART FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DILATED CARDIOMYOPATHY | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. AORTIC + MITRAL VALVE DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. / | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: SENESCENCE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] M.D. | D26339 | ▶ 4/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A.K. CHOPRA, 3455 WILKENS AVE. BALTO. MD. 21229

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 1 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

ITEM# 1 FILM #G 650 5/2/89 PER: F. H. JA

89 11185

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH | |
| Joseph | R. | Meyers A.K.A. MYERS | | 4-26-89 | 11:33AM | M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) | |
| 220-09-6502 | X 1 M 2 F | 76 YRS. | | 11-11-12 | MD | |
| 9a. FACILITY NAME (If not institution, give street and number) | | 9b. CITY, TOWN OR LOCATION OF DEATH | | 9c. COUNTY OF DEATH | | |
| 2464 Brentwood Avenue | | Baltimore City | | | | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? | | |
| MD | | BALTIMORE CITY | | 1 X YES 2 ☐ NO | | |
| 10e. STREET AND NUMBER | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? | | |
| 2464 BRENTWOOD AVENUE | | 21218 | | USA | | |
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | | 14. RACE — American Indian, Black, White, etc. | | |
| 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced | 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 X NO Specify: | | Specify: BLACK | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | |
| Elementary/Secondary (0-12): UNKNOWN | College (1-4 or 5+): | UNKNOWN | | RETIRED | | |
| 17. FATHER'S NAME (First, Middle, Last) | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | |
| JAMES MYERS | | ANNIE GREENE | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | |
| ROSE McBRIDE | | 2464 BRENTWOOD AVENUE/BALTIMORE, MD 21218 | | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | | |
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | KING MEMORIAL PARK CEMETERY | | RANDALLSTOWN, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY | | | | |
| ▶ [signature] | | WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE | | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Arteriosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO — INQUIRY

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? X YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ 4-27-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Charles P. Kokes, M.D. 111 Penn Street, Baltimore, MD 21201 VC

31. DATE FILED (Month, Day, Year): MAY 1 1989
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11186

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rose Carmella Marcellino
2. DATE OF DEATH: Month Apr. 30, Day 1989, Year
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 217-48-3555
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 97 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 12/20/91
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Agnes HospitalCPER
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 1210 Haverhill Road
10f. ZIP CODE: 21229
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 8+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Joseph Carmella
18. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Natale
19a. INFORMANT'S NAME (Type/Print): Michael Heaney
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1834 Portship Road Dundalk Md 21222
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery
20c. LOCATION — City or Town, State: Baltimore City
21. SIGNATURE OF FUNERAL SERVICE LICENSEE
22. NAME AND ADDRESS OF FACILITY: AMBROSE FUNERAL HOME, 1328 SULPHUR SPRING ROAD, ARBUTUS, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiorespiratory Arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): | b. Atherosclerotic Cardiovascular Disease | yrs. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): | c. Hypertensive Cardiovasc. dis. | yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Asthmatic Bronchitis, Intermittent.
Cardiac arrhythmia History

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 8 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D-18393
29d. DATE SIGNED (Month, Day, Year): ▶ 5-1-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): D. P. Malayaman, MD. 4001 Wilkens Ave Baltimore 21229
31. DATE FILED (Month, Day, Year): MAY 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 11187

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOSEPH William MAKAR | | | 2. DATE OF DEATH (Month, Day, Year): 4 14 89 | 3. TIME OF DEATH: 2:17 PM |
| 4. SOCIAL SECURITY NUMBER: 219-26-4180 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 51 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12-31-37 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): auto-1200 blk. S. Hanover St. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Balto. City |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore City | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2019 Paulette Road | | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: 1957-1959 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Automotive Mechanic | 16b. KIND OF BUSINESS/INDUSTRY: Marina | |
| 17. FATHER'S NAME (First, Middle, Last): Andrew J. Makar | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary B. Zebron | |
| 19a. INFORMANT'S NAME (Type/Print): Mary B. Makar | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2019 Paulette Road Baltimore, Maryland 21222 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Md. Veterans Crownsville | 20c. LOCATION — City or Town, State: Crownsville, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: C. Richard Gonce | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home | 4001 Ritchie Hwy. Baltimore, Md. 21225 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Fatty liver | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Chronic alcoholism | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☒ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify): Scene |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin M.D. | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 4-15-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. | 111 Penn St., Balto., MD 21201 | |
| 31. DATE FILED (Month, Day, Year): MAY 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Ramsey | |

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11188
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): James Wesley Mills Jr. | | | | | | 2. DATE OF DEATH (Month, Day, Year): 4-25-89 | 3. TIME OF DEATH: 1:40PM M |
| 4. SOCIAL SECURITY NUMBER: 214-62-1765 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 34 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | 7. DATE OF BIRTH (Month, Day, Year): 9-29-54 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): University Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | | | 9c. COUNTY OF DEATH: Balto. City |
| **RESIDENCE OF DECEDENT** | | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Pasadena | | | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7751 Middlegate Court | | | 10f. ZIP CODE: 21122 | | | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electrician | | | | 16b. KIND OF BUSINESS/INDUSTRY: MMR/Foley Contractors |
| 17. FATHER'S NAME (First, Middle, Last): James W. Mills | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Thelma R. Sapp | | | | |
| 19a. INFORMANT'S NAME (Type/Print): Debra S. Mills | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7751 Middlegate Court Pasadena, Maryland 21122 | | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | | | | 20c. LOCATION — City or Town, State: Glen Burnie, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Roy D. Gonce | | | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225 | | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Penetrating Cranio-cerebral Injury | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 4-24-89 | 12:50P M | 1 ☒ YES 2 ☐ NO | Subject struck by conduit wire |

28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): construction site

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Rte. I295 & 32, Anne Arundel Co.

29a. CERTIFIER (Check only one):
☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Charles P. Kokes MD | OCME | ▶ 4-26-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn Street, Baltimore, MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 1 1989 | Julia Davidson-Randall |

DHMH-t a Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11189

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GEORGE J. MEALEY | | | 2. DATE OF DEATH (Month / Day / Year): 4 / 23 / 89 | 3. TIME OF DEATH: 7:55 PM |
| 4. SOCIAL SECURITY NUMBER: 024-26-5281 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 53 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 01 / 06 / 36 | 8. BIRTHPLACE (State or Foreign Country): BOSTON MASSACHUSETTS |
| 9a. FACILITY NAME (If not institution, give street and number): THE DEATON HOSPITAL + MEDICAL CE | | 9b. CITY, TOWN OR LOCATION OF DEATH: 601 S CHARLES ST, BALTIMORE | | 9c. COUNTY OF DEATH: --- |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: CATONSVILLE | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 402 A SHADE TREE PLACE | | 10f. ZIP CODE: 21228 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: 1953 - 1957 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 6+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SALES | 16b. KIND OF BUSINESS/INDUSTRY: BEAUTICIAN SUPPLY |
| 17. FATHER'S NAME (First, Middle, Last): CHARLES MEALEY | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): THERESA MAHER | |
| 19a. INFORMANT'S NAME (Type/Print): JANET MEALEY | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 402 A SHADE TREE PLACE, CATONSVILLE, MD. 21228 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MARYLAND VETERANS CEMETEY | 20c. LOCATION — City or Town, State: OWINGS MILLS, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Russell Witzke | | 22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Laryngeal CA, metastatic to spine & involvement of respiratory muscles | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

(a) quadriplegia 2° to # b, above
Urinary incontinence, chronic, 2° (a) & neurogenic bladder

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER: D28199 | 29d. DATE SIGNED (Month, Day, Year): 4-24-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BRUCE KINOSIAN M.D. | DEATON MEDICAL CENTER, BALTIMORE, MD. | |
| 31. DATE FILED (Month, Day, Year): APR 27 1989 | 32. REGISTRAR'S SIGNATURE: Julia Dickerson Rankin | |

DHMH-16 Rev 1/89

89 11190

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Neal — AKA: Neal McAllister, Jr. Mac Allister
2. DATE OF DEATH — MONTH DAY YEAR: 4-26-89
3. TIME OF DEATH: 3:51PM M
4. SOCIAL SECURITY NUMBER: 240-70-6482
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 43 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 24, 1945
8. BIRTHPLACE (State or Foreign Country): N. Carolina
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1415 Poplar Grove St.
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 10 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer
16b. KIND OF BUSINESS/INDUSTRY: Construction
17. FATHER'S NAME (First, Middle, Last): Neal Alex McAllister, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lena McMillan
19a. INFORMANT'S NAME (Type/Print): Lena McAllister
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 61. Clarkton. N.C. 28433
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Zion Cemetery
20c. LOCATION — City or Town, State: Lisbon. N.C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. George Altenburg
22. NAME AND ADDRESS OF FACILITY: ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore. MD 21214

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sarcoidosis and pulmonary hypertension
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO — INQUIRY
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A. Korell
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ 4-27-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn Street, Baltimore, Md 21201 VC
31. DATE FILED (Month, Day, Year): MAY 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MA 203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be used as the burial-transit permit.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11191
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 only should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): William Sylvester Miller | | | 2. DATE OF DEATH (Month / Day / Year): 04/14/89 | 3. TIME OF DEATH: 2317 M |
| 4. SOCIAL SECURITY NUMBER: 217072266 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 06/25/1916 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: N/A |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: N/A | 10c. CITY, TOWN OR LOCATION: BALTO. | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 734 West Hills PKY- Baltimore, Md. | | 10f. ZIP CODE: 21229 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: N/A | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: N/A | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 8+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Superintendent | 16b. KIND OF BUSINESS/INDUSTRY: Mt. Royal Builders Co. | |
| 17. FATHER'S NAME (First, Middle, Last): Mark E. Miller | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Cora E. Sutch | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Ellen M. Miller | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 734 West Hills Pkwy.-Balto., Md. 21229 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____ 4-18-89 | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lakeview Mem.Pk.Cemetery | 20c. LOCATION — City or Town, State: Sykesville,Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: G.Truman Schwab | | 22. NAME AND ADDRESS OF FACILITY: 5151 Baltimore National Pike Baltimore, Md. 21229 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio Pulmon Arrest — 1 hr

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Carcinoma of lung (RT) — 8 mos

DUE TO (OR AS A CONSEQUENCE OF):

c. _____

DUE TO (OR AS A CONSEQUENCE OF):

d. _____

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Cliff Ratliff Jr M.D. | 29c. LICENSE NUMBER: D 09762 | 29d. DATE SIGNED (Month, Day, Year): 4/15/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CLIFF RATLIFF, JR. WESTVIEW MALL 21227

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 19 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11192

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE F. MEILLER
2. DATE OF DEATH (Month, Day, Year): 4 23 89
3. TIME OF DEATH: 10:07 AM
4. SOCIAL SECURITY NUMBER: 212-07-7160
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 72 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): Sept. 25, 1916
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 4622 Harcourt Rd.
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4622 Harcourt Rd.
10f. ZIP CODE: 21214
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Salesman
16b. KIND OF BUSINESS/INDUSTRY: Taylor Supply Co.
17. FATHER'S NAME (First, Middle, Last): Frederick Meiller
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Elizabeth Stenger
19a. INFORMANT'S NAME (Type/Print): Timothy Meiller
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12090 Learfield Circle, Lutherville, Md. 21093
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Redeemer Cemetery 4/26/89
20c. LOCATION — City or Town, State: Balto., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ADENOCARCINOMA OF RECTUM | 6 YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Richard S. Kaplan MD
29c. LICENSE NUMBER: D23827
29d. DATE SIGNED (Month, Day, Year): ▶ 4/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard Kaplan M.D. University Hospital
31. DATE FILED (Month, Day, Year): APR 25 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Rudacille

OHMH-18 Rev 1/89

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

30

89 11192

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11193

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): PAUL SEIBERT MILLER, JR. | | | 2. DATE OF DEATH (Month, Day, Year): April 30, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 217-14-2181 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12-7-1923 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): Residence - 6508 Hartwait Street | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore City | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 6508 Hartwait Street | | 10f. ZIP CODE: 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Meat Salesman | 16b. KIND OF BUSINESS/INDUSTRY: A.W. Schmidt | | |
| 17. FATHER'S NAME (First, Middle, Last): Paul S. Miller, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Pipp | | |
| 19a. INFORMANT'S NAME (Type/Print): Sylvia D. MIller | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6508 Hartwait Street, Baltimore, MD 21224 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Cemetery 5/5/89 | 20c. LOCATION — City or Town, State: Owings Mills, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Charles W. Finch | 22. NAME AND ADDRESS OF FACILITY: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Baltimore, MD 21222 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Lung Adenocarcinoma | 5 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | | |
|---|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Charles Padgett MD | 29c. LICENSE NUMBER: D15546 | 29d. DATE SIGNED (Month, Day, Year): 5-1-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Padgett, Charles A, 5601 Loch Raven Blvd., 21239 | | |
| 31. DATE FILED (Month, Day, Year): MAY 3 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11194

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MERTHA L. MORRISON | | | 2. DATE OF DEATH (Month, Day, Year): 4 / 26 / 89 | 3. TIME OF DEATH: 1:35 A M |
| 4. SOCIAL SECURITY NUMBER: 426-42-6047 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 59 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10-16-29 | 8. BIRTHPLACE (State or Foreign Country) |
| 9a. FACILITY NAME (If not institution, give street and number): MERCY MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4601 PALL MALL ROAD | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Blk |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): JAMES DANIEL HUSBAND | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): GENEVIA BROWN | |
| 19a. INFORMANT'S NAME (Type/Print): MRS LOINSYA BAYLER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2849 GATEHOUSE DR BALTO MD | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT ZION CEM | 20c. LOCATION — City or Town, State: BALTO MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph L. Russ | | 22. NAME AND ADDRESS OF FACILITY: JOSEPH L. RUSS 2222 W. NORTH AVE 21216 | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SEPSIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

severe metabolic acidosis, Gangrenous small bowel, Renal failure

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Fernando Ferro MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/26/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FERNANDO FERRO MD, MERCY MED. CENTER, BALTIMORE, MD. 21202

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 28 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11195
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page [illegible] by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, [illegible] be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner [illegible] at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) SIMMIE MCBRIDE / SIMMIE MC BRIDE | | | 2. DATE OF DEATH MONTH 4 DAY 17 YEAR 89 89 | 3. TIME OF DEATH 0525 HRS M |
| 4. SOCIAL SECURITY NUMBER 245-25-0877A | 5. SEX 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday) 74 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) 12-25-14 |
| 8. BIRTHPLACE (State or Foreign Country) S.C. | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) CHURCH HOME HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | 9c. COUNTY OF DEATH | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE MD | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER 1751 NORTH CHESTER STREET | | 10f. ZIP CODE 21213 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 5th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FOLKLIFT OPERATOR | 16b. KIND OF BUSINESS/INDUSTRY NA |
| 17. FATHER'S NAME (First, Middle, Last) ROBERT McBRIDE | 18. MOTHER'S NAME (First, Middle, Maiden Surname) AMY | |
| 19a. INFORMANT'S NAME (Type/Print) IDA MAE JOHNSON | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1751 NORTH CHESTER STREET/BALTIMORE, MD. 21213 | |
| 20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY | 20c. LOCATION — City or Town, State BALTIMORE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CARDIOPULMONARY ARREST / ~~CARDIOPULMONARY ARREST~~ | MINUTES |
| DUE TO (OR AS A CONSEQUENCE OF): b. | PNEUMONIA / PNEUMONIA | DAYS |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC BRAIN SYNDROME, CHRONIC DIARRHEA, MALNUTRITION, ANEMIA, DENYDRATION, RENAL FAILURE / ~~CHRONIC BRAIN SYNDROME, CHRONIC DIARRHEA MALNUTRITION, ANEMIA, DENYDRATION RENAL FAILURE~~

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER JORGE C. SECADA LOVIO MD / ~~JORGE C. SECADA LOVIO MD~~ | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4-17-89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type/Print) JORGE C. SECADA-LOVIO, MD. CHURCH HOSPITAL, BALT., MD 21231 | | | |
| 31. DATE FILED (Month, Day, Year) APR 18 1989 | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | |

DHMH-16 Rev 1/89

89 11196

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 ... the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director ... detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

10

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Sara Amy McDede | | 2. DATE OF DEATH (Month, Day, Year): 4 28 89 | 3. TIME OF DEATH: 6:30 p.m. |
| 4. SOCIAL SECURITY NUMBER: 214-14-0195 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 1/27/1904 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Church Home Nursing Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3231 Kenyon Ave. | | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cashier | 16b. KIND OF BUSINESS/INDUSTRY: Hutzlers Dept. Store | |
| 17. FATHER'S NAME (First, Middle, Last): George R. Crotsley | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Nunnaly | | |
| 19a. INFORMANT'S NAME (Type/Print): Bruce M. Harman | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1526 Castlerock Rd. Houston, Texas 77090 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount Crematory | 20c. LOCATION — City or Town, State: Balto, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert M. Kratz | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home Inc. 6500 York Rd. 21212 | | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Renal Failure
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DM

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) DOMICILIARY

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
25b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER: D16619 | 29d. DATE SIGNED (Month, Day, Year): 4-28-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C. VERGARA-SOARES 100 N. BROADWAY BALT. MD. 21231

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 1136

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11197
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 1314/ BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) MAZER, Dorothy — DOROTHY M. MAZER | | 2. DATE OF DEATH MONTH 4 DAY 15 YEAR 89 | 3. TIME OF DEATH 2PM M |
| 4. SOCIAL SECURITY NUMBER 218-01-4852 | 5. SEX 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday) 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) 03-25-1918 |
| 8. BIRTHPLACE (State or Foreign Country) MD | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Levindale Hebrew Geriatric + Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE MD | 10b. COUNTY BALTIMORE | 10c. CITY, TOWN OR LOCATION PIKESVILLE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER 5 TROTTERS COURT APT. T-4 | | 10f. ZIP CODE 21208 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY HOMEMAKER | |
| 17. FATHER'S NAME (First, Middle, Last) SAMUEL HOLZMAN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA BERNSTEIN | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. HARMOND AMERNICK | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8200 BRATTLE RD. BALTIMORE, MD. ( 21208) | | |
| 20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ANSHE EMUNAH AITZ CHAIM CEM. | 20c. LOCATION — City or Town, State BALTIMORE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Joel D Lewis | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Metastatic breast carcinoma
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
NIDDM

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 25. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 26d. DESCRIBE HOW INJURY OCCURED | | |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER Joseph Gallo MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4-15-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOSEPH GALLO LEVINDALE GER. CTR. Balto 21215 | | |
| 31. DATE FILED (Month, Day, Year) APR 20 1989 | 32. REGISTRAR'S SIGNATURE Julia Davidson-Ramsey | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11198

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Dorothy Mae McLain / Dorothy McClain | | | 2. DATE OF DEATH (Month, Day, Year) 04-24-89 | 3. TIME OF DEATH 6:00 AM |
| 4. SOCIAL SECURITY NUMBER 212-07-2626A | 5. SEX 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday) 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year) 05-26-05 | 8. BIRTHPLACE (State or Foreign Country) Maryland |
| 9a. FACILITY NAME (If not institution, give street and number) Seton Hill Manor | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH City |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE Maryland | 10b. COUNTY Anne Arundel | 10c. CITY, TOWN OR LOCATION Glen Burnie | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER 8916 Park South Drive | 10f. ZIP CODE 21061 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Insurance Adjuster | 16b. KIND OF BUSINESS/INDUSTRY Insurance |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last) John Wesley Alton | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Nettie Mae King |
| 19a. INFORMANT'S NAME (Type/Print) Paul W. Lowe | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25505 Creighton Avenue 21234 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Security Process, Inc | 20c. LOCATION — City or Town, State Catonsville, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ S. M. Loewner | 22. NAME AND ADDRESS OF FACILITY Cremation Society of MD Baltimore, Maryland 21228 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Severe Arteriosclerotic vascular disease | 5 yrs. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

(Cerebrovascular (CVA) sided Stroke)
Seizure disorder

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER Jaime Punzalan MD | 29c. LICENSE NUMBER D15124 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/24/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JAIME PUNZALAN - 5214 Harford Rd. Balto. 21214

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year) APR 26 1989 | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): SIMMIE MCLAURIN

**2. DATE OF DEATH** (Month, Day, Year): APRIL 27, 1989

**3. TIME OF DEATH**: 4:19 A M

**4. SOCIAL SECURITY NUMBER**: 216-50-0414

**5. SEX**: 1 ☒ M 2 ☐ F

**6. AGE** (In yrs. last birthday): 40 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 6-22-1948

**8. BIRTHPLACE** (State or Foreign Country): South Carolina

**9a. FACILITY NAME** (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTIMORE CITY

**9c. COUNTY OF DEATH**: BALTIMORE

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: Balto.

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 1823 N. Broadway

**10f. ZIP CODE**: 21213

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: Black

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Disable

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): Eli MCLaurin

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Geneva McLaurin

**19a. INFORMANT'S NAME** (Type/Print): Eli McLaurin

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1823 N. Broadway

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Mt Zion Cem

**20c. LOCATION — City or Town, State**: Balto MD.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE** ▶ [signature]

**22. NAME AND ADDRESS OF FACILITY**: Jeff Miller Fh 1639 N. Broadway

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. BACTERIAL SEPSIS — 13 days

DUE TO (OR AS A CONSEQUENCE OF):
b. SACRAL DECUBITI — 10 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
c.

DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

Pneumonia

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☐ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☒ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year):

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**:

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify):

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: [signature] JUNIOR ASSISTANT RESIDENT

**29c. LICENSE NUMBER**:

**29d. DATE SIGNED** (Month, Day, Year) ▶ 4-27-89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): ERIC B. LIEBERMAN 600 N. WOLFE ST, BALTIMORE MD 21205

**31. DATE FILED** (Month, Day, Year): MAY 2 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-16 Rev 1/89

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item 4, film G651 5-9-89 I.J.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11200

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LEO MATUSZAK, ~~LEO~~ | | | 2. DATE OF DEATH (Month, Day, Year): 4 27 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 217-05-1915 1436 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2-19-15 | 8. BIRTHPLACE (State or Foreign Country): PA. |
| 9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: — |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MD | 10b. COUNTY: — | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 5100 EDGAR TERRACE | | 10f. ZIP CODE: 21214 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10TH; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FOUNDARY WORKER | | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): THEODORE MATUSZAK | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ~~[illegible]~~ WANDA UNKNOWN | | |
| 19a. INFORMANT'S NAME (Type/Print): DOLORES GNACEK | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5547 LANHAM WAY BALTO, MD 21206 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. STANISLAUS CEM | | 20c. LOCATION — City or Town, State: BALTO. MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: David J. Weber | | 22. NAME AND ADDRESS OF FACILITY: JOHN M. WEBER & SONS INC. 401 S. CHESTER ST. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cirrhosis | 20 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |
|---|---|

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ |
|---|---|---|
| S.M. Cabbell | | 4/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 2 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 11201

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Thomas Walter Mihm Sr. | | | 2. DATE OF DEATH (Month, Day, Year): 4 / 18 / 89 | 3. TIME OF DEATH: 9:51 M |
| 4. SOCIAL SECURITY NUMBER: 216076815 | 5. SEX: 1 [X] M 2 [ ] F | 5. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2/13/11 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): HARBOR HOSPITAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: Balto. City |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Balto. City | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3925 Brooklyn Avenue | | 10f. ZIP CODE: 21225 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade; College (1-4 or 8+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Supervisor | 16b. KIND OF BUSINESS/INDUSTRY: Schmidts Bakery | |
| 17. FATHER'S NAME (First, Middle, Last): John Mihm | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosa | |
| 19a. INFORMANT'S NAME (Type/Print): Beverly Myer | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1206 Hill Creek Road Pasadena, Maryland 21122 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Brooklyn, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: C. Richard Gonce | | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ischemic right leg. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. cardiac arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. acut renal failen | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD. | 29c. LICENSE NUMBER: D24076 | 29d. DATE SIGNED (Month, Day, Year): 4/18/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] MD.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 18 1989 | 32. REGISTRAR'S SIGNATURE: Judie Davidson-Randall |

DHMH-16 Rev 1/89

89 11201

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11202
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Joseph A. MANNION | | | 2. DATE OF DEATH (Month, Day, Year): April 28, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 217-22-0845 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Dec 24, 1906 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Melchor Nusing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: ---------- |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: ---------- | 10c. CITY, TOWN OR LOCATION: Baltimore City. | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1370 E. Sherwood Avenue | | 10f. ZIP CODE: 21239 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FIREMAN | 16b. KIND OF BUSINESS/INDUSTRY: BALTO. CITY FIRE DEPT. | |
| 17. FATHER'S NAME (First, Middle, Last): MARTIN MANNION | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): BARBARA SEMLA | |
| 19a. INFORMANT'S NAME (Type/Print): Bernadette Walls | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1370 E. Sherwood Avenue Baltimore, MD 21239 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John J. Dippel | | 22. NAME AND ADDRESS OF FACILITY: Dippel Funeral Home, Inc. 7110 Belair Road Baltimore, MD 21206 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute myocardial infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Atherosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Marc D. Sokolow M.D. | 29c. LICENSE NUMBER: D26534 | 29d. DATE SIGNED (Month, Day, Year): April 29, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Marc D. Sokolow, M.D. 333 St. Paul Street BAltimore, Maryland 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall |

DHMH-16 Rev 1/89

89 11202

89 11203

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13[illegible] BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be execu[illegible]ours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

4

3 should

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Frances E. Mercer / Frances Eugene Mercer | | | 2. DATE OF DEATH MONTH 4 DAY 17 YEAR 89 | 3. TIME OF DEATH 6:50 a.m. / 6:30 M |
| 4. SOCIAL SECURITY NUMBER: 21-14-2119 / 219 14 2119 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 87 87 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 6-3-01 | 8. BIRTHPLACE (State or Foreign Country): Md. |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: N/A |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: N/A | 10c. CITY, TOWN OR LOCATION: Baltimore, Md. 21229 | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 5543 Channing Rd.-Baltimore, Md. | 10f. ZIP CODE: 21229 | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: N/A | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: N/A | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A / College (1-4 or 5+): N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife/office work-Hecht's | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): John B. O'Donnell | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Filler |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Delores Carver | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5543 Channing Rd.-Balto., Md. #21229 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-21-89 | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery | 20c. LOCATION — City or Town, State: Balto., Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ G. Truman Schwab | 22. NAME AND ADDRESS OF FACILITY: 5151 Baltimore National Pike Baltimore, Md. 21229 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | cardiopulmonary failure | 10 min |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Sepsis | 1 day. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Small bowel obstruction | ~1 wk |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | GI bleed | ~1 wk. |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sigmoid CA, HTN, ASCVD, CVA, anemia

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: AX435528683 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/17/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JUAN R. GELPI, MD St Agnes Hospital 900 CATON AVE. Balto., Md. | | |
| 31. DATE FILED (Month, Day, Year): APR 19 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11204

DIVISION OF VITAL RECORDS, P.O. BOX 13 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): George Donald Miller | | 2. DATE OF DEATH (Month, Day, Year): April 24 89 | 3. TIME OF DEATH: 1235 P M |
| 4. SOCIAL SECURITY NUMBER: 172.01.1054 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 77 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): Mar. 15, 1912 |
| 8. BIRTHPLACE (State or Foreign Country): Pennsylvania | | | |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: Baltimore City | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Linthicum | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 12 Charles Road | 10f. ZIP CODE: 21090 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired): Supervisor in Engineering Dept. | 16b. KIND OF BUSINESS/INDUSTRY: Westinghouse |
| 17. FATHER'S NAME (First, Middle, Last): George Albert Miller | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances B. Shuman | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. E. Anne Miller | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Security Process, Inc. | 20c. LOCATION — City or Town, State: Catonsville, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. George Hopkins | | 22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. 21061 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CVA - brain stem infarct | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 26d. DESCRIBE HOW INJURY OCCURED | | |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: CRK MD, Resident | 29c. LICENSE NUMBER: AS24 38 528-62 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/24/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Choong R. Kim, MD, St. Agnes Hospital, 900 Caton Ave Bal MD 21229 | | |
| 31. DATE FILED (Month, Day, Year): APR 28 1989 | 32. REGISTRAR'S SIGNATURE: Esther Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11205

DIVISION OF VITAL RECORDS, P.O. BOX 13[illegible] BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Information contained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Grace L. Meyers | | | | 2. DATE OF DEATH (Month, Day, Year): 04 27 89 | 3. TIME OF DEATH: 9:30 P M |
| 4. SOCIAL SECURITY NUMBER: 213-12-0897 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 79 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 03 24 10 | 8. BIRTHPLACE (State or Foreign Country): West Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Belair Convalesarium | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6116 Belair Road | | 10f. ZIP CODE: 21206 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Store Clerk | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): (unknown) Mayhew | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): unknown | |
| 19a. INFORMANT'S NAME (Type/Print): Bettye Watkins | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3600 Flickinger Road, Westminster, Md. 21157 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ A. Alan Seitz Jr. | | 22. NAME AND ADDRESS OF FACILITY: A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Balto., Md. 21211 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. RESPIRATORY FAILURE

DUE TO (OR AS A CONSEQUENCE OF):
b. SEVERE COPD

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. COR PULMONALE

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CAD. DEMENTIA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER: D0834[illegible] | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/28/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3714 HARFORD RD BALTO. MD | | | |
| 31. DATE FILED (Month, Day, Year): MAY 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11206

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page ... by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral ... be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner ... notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GEORGE MCCANDLESS , Sr. | | | 2. DATE OF DEATH (Month, Day, Year): 04 28 89 | 3. TIME OF DEATH: 755 A M |
| 4. SOCIAL SECURITY NUMBER: 217-36-3080 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 02 22 03 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): UNION MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 4006 Falls Road | | 10f. ZIP CODE: 21211 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1925 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Fireman | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): (unknown) McCandless | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): (unknown) | |
| 19a. INFORMANT'S NAME (Type/Print): Marie Kraus | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1465 Roland Heights Ave., Baltimore, Md. 21211 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery | 20c. LOCATION — City or Town, State: Baltimore City, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ A. Alan Seitz, Jr. | | 22. NAME AND ADDRESS OF FACILITY: A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Balto., Md. 21211 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIORESPIRATORY ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. SUSPECTED PULMONARY EMBOLUS | UNK. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- BLEEDING: POSTERIOR NOSE
LOWER GI
- SUSPECTED ABDOMINAL ANEURYSM

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [X] Pending Investigation 6 [ ] Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER: N/A | 29d. DATE SIGNED (Month, Day, Year): ▶ 04/28/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID U. NEWMAN M.D. 201 E. UNIV. PKWAY - Bal. 10 - UNION MEMORIAL HOSP. BALTO. MD 21218

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 1 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11207
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 5 should be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from State.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Judith R. Murphy | | | | 2. DATE OF DEATH (Month, Day, Year): 4-24-89 | 3. TIME OF DEATH: 7:58PM M |
| 4. SOCIAL SECURITY NUMBER: 212-58-5345 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 36 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 2/1/53 | 8. BIRTHPLACE (State or Foreign Country): Kentucky |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Dundalk | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1903 Nevill Road | | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Osborne | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Peggy Centers | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Peggy Stelmack | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4484 Francis Ct. Lilburn, GA 30247 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus Cemetery | 20c. LOCATION — City or Town, State: Baltimore, MD | 4/28/89 |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Scott P. Gardner | 22. NAME AND ADDRESS OF FACILITY: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Baltimore, MD 21222 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Fibrinous pericarditis and bronchopneumonia

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Fibrinous pleuritis, Rheumatoid arthritis, obesity

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 8 ☐ Residence 8 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodwin MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-25-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. | 111 Penn Street, Baltimore, MD 21201 | |
| 31. DATE FILED (Month, Day, Year): APR 28 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11208
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Edith Magdalene Marshall | | | 2. DATE OF DEATH (Month, Day, Year): 4-6-89 | 3. TIME OF DEATH: 6:50AM M |
| 4. SOCIAL SECURITY NUMBER: 223-38-3414 | 5. SEX: 1 ☐ M 2 ☒ F | 8. AGE (In yrs. last birthday): 56 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 07-22-32 | 8. BIRTHPLACE (State or Foreign Country): Va. |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md. | 10b. COUNTY: ---------- | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 713 Umbra Street | | 10f. ZIP CODE: 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housework | | 16b. KIND OF BUSINESS/INDUSTRY: At Home |
| 17. FATHER'S NAME (First, Middle, Last): Stephen Floyd | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara Perry | | |
| 19a. INFORMANT'S NAME (Type/Print): William R. Marshall Sr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 713 Umbra Street Baltimore, Md. 21224 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery | | 20c. LOCATION — City or Town, State: Eastwood, Balto. Co., Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles D. Zeiler | | 22. NAME AND ADDRESS OF FACILITY: Charles S. Zeiler & Son Inc. 6224 Eastern Ave. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic Cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Margarita A. Korell | OCME | ▶ 4-6-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn Street, Baltimore, MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 7 1989 | Gene Marker-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11209
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EDWARD S. MALECKI | | | 2. DATE OF DEATH (Month, Day, Year): April 4, 1989 | 3. TIME OF DEATH: 8:53 P. M |
| 4. SOCIAL SECURITY NUMBER: 216-03-7933 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Oct. 1, 1910 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Med. Ctr. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Maryland | | 9c. COUNTY OF DEATH: - |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: - | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 6307 Brown Ave. Baltimore, Md. | | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+): 0 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver | 16b. KIND OF BUSINESS/INDUSTRY: Transportation | |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Malecki | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Agnes Borowski | |
| 19a. INFORMANT'S NAME (Type/Print): Susan Nieto | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2506 Ailsa Ave. Baltimore, Maryland 21214 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Stanislaus Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Raymond A. Weber | 22. NAME AND ADDRESS OF FACILITY: George A. Weber & Sons Inc. 705 S. Ann St. Balto. Md. 21231 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. cardiac arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Coronary artery disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Diabetes Mellitus | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mary Brogan MD | 29c. LICENSE NUMBER: D33756 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mary Brogan, MD, Witzke Medical Ctr. 3711 Bank St. Baltimore, Maryland 21224

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 07 1989 | 32. REGISTRAR'S SIGNATURE: Lia Knudson-Randell |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11210 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): MURRAY MARY LOU (Mary Lou Murray)

**2. DATE OF DEATH** Month: 4 Day: 12 Year: 89

**3. TIME OF DEATH**: 3 32 PM

**4. SOCIAL SECURITY NUMBER**: 219-52-3598

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 41 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 6/7/47

**8. BIRTHPLACE** (State or Foreign Country): COLUMBIA, SC.

**9a. FACILITY NAME** (If not institution, give street and number): EXTENDED CARE UNIT UNION MEMORIAL HOSP.

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTO. MD 21218

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 1908 E. 31st St. Baltimore MD

**10f. ZIP CODE**: 21218

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A

**11. MARITAL STATUS** 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENOENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: BLACK

**15. OECEOENT'S EOUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): UNKnown
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): UNEMployed

**16b. KIND OF BUSINESS/INDUSTRY**: NA

**17. FATHER'S NAME** (First, Middle, Last): Nathaniel Murray Sr.

**18. MOTHER'S NAME** (First, Middle, Maiden Surname):

**19a. INFORMANT'S NAME** (Type/Print): JOE L. GREEN

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1908 E. 31ST Street/Balto. mo.

**20a. METHOD OF DISPOSITION** 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Eastview Mem. Pk. Gm.

**20c. LOCATION — City or Town, State**: Dundalk, MD

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Julia R. March

**22. NAME AND ADDRESS OF FACILITY**: William C. March Funeral Home 1101 E. North Avenue 21202

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) →
a. Sepsis

OUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Intra abdominal abcess — 2 months

OUE TO (OR AS A CONSEQUENCE OF):
c. Metastatic leiomyosarcoma of the small bowel — 21 months

DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF OEATH?** 1 ☐ YES 2 ☒ NO

**25. WAS CASE REFERRED TO MEOICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF OEATH** (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH** 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. OESCRIBE HOW INJURY OCCUREO**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Alicia A. Cool-Foley MD

**29c. LICENSE NUMBER**: D 30717

**29d. DATE SIGNED** (Month, Day, Year): 4/13/89

**30. NAME AND AOORESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27)** (Type, Print): Alicia A. Cool-Foley MD 201 E University Pkwy Baltimore Md 21218

**31. DATE FILED** (Month, Day, Year): APR 14 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Rendeke

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11211
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): VIOLET MARZEC | | 2. DATE OF DEATH (Month, Day, Year): 4-13-89 | 3. TIME OF DEATH: 9:42 PM |
| 4. SOCIAL SECURITY NUMBER: 191-07-9413 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 1 25 15 |
| 8. BIRTHPLACE (State or Foreign Country): Pennsylvania | | | |
| 9a. FACILITY NAME (If not institution, give street and number): church hospital corporation | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: MD | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: - | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3106 O'Donnell Street | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: - | |
| 17. FATHER'S NAME (First, Middle, Last): George Smeltzer | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lydia Maddocks | | |
| 19a. INFORMANT'S NAME (Type/Print): Patricia Saulsbury | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 837 S. Ellwood Avenue, Baltimore, Md. 21224 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus Cem. | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | 22. NAME AND ADDRESS OF FACILITY: Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | ACUTE MYOCARDIAL INFARCTION | Min. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | ARTERIOSCLEROSIS | Years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): N/A | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: A. P. Nazemi M. D. | 29c. LICENSE NUMBER: CHURCH H. | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/13/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A.P. NAZEMI, M.D. CHURCH HOSPITAL 100NORTH BROADWAY 21231

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Tindon-Lindsay |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11212

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MABEL I. MATTHEWS
2. DATE OF DEATH (Month, Day, Year): 04 01 89
3. TIME OF DEATH: 910 A M
4. SOCIAL SECURITY NUMBER: 214 22 5466
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 71 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 05/30/17
8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4400 W. Forest Park Ave
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th | College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): James W. Tyler
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mabel Carter
19a. INFORMANT'S NAME (Type/Print): Aubrey Matthews
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4400 W. Forest Park Ave Balto, Md 21207
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery
20c. LOCATION — City or Town, State: Baltimore, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Sala March
22. NAME AND ADDRESS OF FACILITY: March F.H. Wabash Ave

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. SEPSIS
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. ACUTE RENAL FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

1 week

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 9 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: 9457
29d. DATE SIGNED (Month, Day, Year): ▶ 04 01 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): T. MEHREL, MD SINAI HOSPITAL BALTIMORE
31. DATE FILED (Month, Day, Year): APR 07 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Rapalee

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11213
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be retained by the funeral director. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ALTON McCOY | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 10 89 | 3. TIME OF DEATH: 7:15 PM |
| 4. SOCIAL SECURITY NUMBER: 215-10-0499 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): APRIL 10 09 | 8. BIRTHPLACE (State or Foreign Country) |
| 9a. FACILITY NAME (If not institution, give street and number): Chas. H. Powell 1306 W Northave | | 9b. CITY, TOWN OR LOCATION OF DEATH: Balto. | 9c. COUNTY OF DEATH | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Balto. Md. | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 1725 N. Pulaski St | | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Long Shoreman | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Ed. McCoy | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Katie C. McCollum | | |
| 19a. INFORMANT'S NAME (Type/Print): Marshall Generette | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1306 Walters Woods Rd | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Veterans Mem. Park | 20c. LOCATION — City or Town, State: Columbia, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Chas. H. Powell | | 22. NAME AND ADDRESS OF FACILITY: 1306 W. North Ave - 21217 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arreat, shock, or head failure. Llet only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Terminal Metastatic Cancer of Prostate Gland | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significent conditions contributing to death but not resulting in the underlying causa given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 X NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) |
|---|---|
| 1 ☐ YES 2 X NO | HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Bernardo D. Gonzales Jr MD | D18711 | ▶ APRIL 10 89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): BERNARDO D. GONZALES JR MD. — 2000 W. BALTIMORE ST, Md. 21223

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 13 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 11214

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Part 6 must be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EVA MCCOY
2. DATE OF DEATH — MONTH: 4 DAY: 1 YEAR: 89
3. TIME OF DEATH: 1 43 AM
4. SOCIAL SECURITY NUMBER: 216-22-4429
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7-17-1909
8. BIRTHPLACE (State or Foreign Country): S.C.
9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CTR
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

**RESIDENCE OF DECEDENT**

10a. STATE: Md.
10b. COUNTY: City
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2715 Woodland ave.
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): ✓ — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOMESTIC
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Joe Henry
18. MOTHER'S NAME (First, Middle, Maiden Surname): Virginia Toney
19a. INFORMANT'S NAME (Type/Print): Gladys Bartee
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3412 Parkington Baltimore, Md
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place):
20c. LOCATION — City or Town, State:
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James G. Morton Jr.
22. NAME AND ADDRESS OF FACILITY: Morton & Sons Funeral Home 1701-31 Laurens ST

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Obstructive Lung Disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Cardiac Failure
DUE TO (OR AS A CONSEQUENCE OF):
d. hypothyroidism

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 5 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 5 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD. GETSNER
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/89.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Liberty Medical CTR.
31. DATE FILED (Month, Day, Year): 4/1/89 APR 4
32. REGISTRAR'S SIGNATURE: 1989 Julia Davidson-Randall

DHMH-16 Rev 1/89

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3 068 52 79 A
MCCALLUM, LAWRENCE
07/09/23 M

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11215

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LAWRENCE J. MCCALLUM, SR. | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 6, 1989 | 3. TIME OF DEATH: 12:45A M |
| 4. SOCIAL SECURITY NUMBER: 246-24-3077 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7-7-24 | 8. BIRTHPLACE (State or Foreign Country): South Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: N/A | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1500 N. EDEN ST. 2nd FLOOR | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machine Operator | 16b. KIND OF BUSINESS/INDUSTRY: Industrial Paper | |
| 17. FATHER'S NAME (First, Middle, Last): NATHANIEL MCCALLUM | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ELLA JANE | | |
| 19a. INFORMANT'S NAME (Type/Print): LOU Pearl McCALLUM | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 43 Mercury Ct. Balto Md. 21244 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Kings Memorial Park 4/8/89 | 20c. LOCATION — City or Town, State: Randallstown, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Rodney S. Sykes | 22. NAME AND ADDRESS OF FACILITY: RODNEY T. SYKES FUNERAL SERVICE OFFICE: 4644 PIMLICO ROAD BALTIMORE, MD. 21215 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Subarachnoid hemorrhage | 48 hours |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D15320 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/6/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHNS HOPKINS 600 NORTH WOLFE STREET BALTIMORE, MARYLAND 21205 | | | |
| 31. DATE FILED (Month, Day, Year): APR 07 1989 | 32. REGISTRAR'S SIGNATURE: [signature] | | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

Items 23a thu 28f Per M.E. Filmg653 7/28/89cg

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11216
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Theodore McLaurin | | | 2. DATE OF DEATH (Month, Day, Year): 4-6-89 | 3. TIME OF DEATH: 7:45AM M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 30 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3 13 1950 | 8. BIRTHPLACE (State or Foreign Country) |
| 9a. FACILITY NAME (If not institution, give street and number): Church Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: 531 Lakewood Ave, 2120 | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 537 Lakewood Ave, 2120 | | 10f. ZIP CODE: 21205 | | 10g. CITIZEN OF WHAT COUNTRY? USA. |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None | | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): Eli McLaurin | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Geneva McLaurin | | |
| 19a. INFORMANT'S NAME (Type/Print): Eli McLaurin | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1823 N. Broadway 21213 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt Zion Cem. | 20c. LOCATION — City or Town, State: Balto. Cem. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Scott Miller F.H. 1639 N. Broadway | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cirrhosis of the liver with complications | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Retroperitoneal hematoma

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☒ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 3/21/89 | 28b. TIME OF INJURY: Unk M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: Subject assulted | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Street | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1800 Block Register St. Baltimore City, Md. | |

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | OCME | ▶ 4-7-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD

VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 13 [illegible] | Julia Davidson Randall |

OHMH-18 Rev 1/89

89 11216

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11217

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Albert Mclendon | | | | 2. DATE OF DEATH (Month / Day / Year): 4 / 9 / 89 | 3. TIME OF DEATH: 12:17 a.m. | |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 38 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10-21-50 | 8. BIRTHPLACE (State or Foreign Country): Balto. Md | |
| 9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH | | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTO. Md | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 5219 Alhambra Balto. Md | 10f. ZIP CODE: 21212 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): NONE; College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NONE | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Robert McLENDON | 18. MOTHER'S NAME (First, Middle, Maiden Surname): JESSIE HAMILTON |
| 19a. INFORMANT'S NAME (Type/Print): Jessie McLENDON | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5219 Alhambra AVE |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. CALVARY CEM. | 20c. LOCATION — City or Town, State: BROOKLYN. Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph B. Locke, JR | 22. NAME AND ADDRESS OF FACILITY: 1304 N. Central Ave. Balto. Md. 21202 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Probable Pulmonary embolism. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Lateral Wall Myocardial Infarction. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☐ YES 2 ☒ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Anthony Macasieb D.O. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/9/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Anthony Macasieb DO 4412 Falls Bridge Dr. Apt H Balt md 21211

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 11 1989 | 32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11218

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the Mail-Form permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Harmon Raymond McKinney | | | | 2. DATE OF DEATH (Month, Day, Year): 4-5-89 | 3. TIME OF DEATH: 8:15AM M |
| 4. SOCIAL SECURITY NUMBER: 242-36-8280 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Feb. 6,1921 | 8. BIRTHPLACE (State or Foreign Country): N. Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): Front yard at steps-2808 Light Street | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: Balto. City |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Balto. City | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2808 S. Light Street | | 10f. ZIP CODE: 21230 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): (unknown) College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Painter | 16b. KIND OF BUSINESS/INDUSTRY: Construction | |
| 17. FATHER'S NAME (First, Middle, Last): (unknown) | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): (unknown) | |
| 19a. INFORMANT'S NAME (Type/Print): Mary Miller | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6200 Plantview Way Baltimore, Md. 21224 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Eastview Memorial Park | 20c. LOCATION — City or Town, State: Dundalk, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donna M Braniecki | | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypertensive arteriosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease and

Chronic alcoholism

24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home [X] Residence 8 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. Md | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-5-89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle,Jr.,M.D. | 111 Penn Street,Baltimore,MD 21201 | | |
| 31. DATE FILED (Month, Day, Year): APR 12 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

DHMH-16 Rev 1/89

89 11218

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11219
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Etta molofsky | | | 2. DATE OF DEATH: MONTH 4 DAY 11 YEAR 89 | 3. TIME OF DEATH: 2 18 PM |
| 4. SOCIAL SECURITY NUMBER: 212-36-7194 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11/11/00 | 8. BIRTHPLACE (State or Foreign Country): RUSSIA |
| 9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | | BALTIMORE | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 7024 SURREY DRIVE | 21215 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 4 | | HOUSEWIFE | AT HOME |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| MORRIS EUDELL | SARAH UNKNOWN |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MRS. CHARLOTTE VEIN | 6702 MAURLEEN RD. BALTO, MD 21209 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | MOSES MONTEFIORE | BALTIMORE, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Jay Lewis | SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. cardiac arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. myocardial infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. pulmonary edema | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Vicki L. Starr, MD | 9465 | ▶ 4/11/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Vicki L. Starr, MD Sinai Hospital

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 14 1989 | Julie Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11220

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be removed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 shall be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified before...**

### TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jessie A. Mullin
2. DATE OF DEATH — MONTH: 4 DAY: 3 YEAR: 89
3. TIME OF DEATH: 12:20 AM
4. SOCIAL SECURITY NUMBER: 225-01-5709
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-13-18
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Poplar Manor Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: USA
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3313 Poplar Street
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES: N/A
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: N/A
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 4 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction Worker
16b. KIND OF BUSINESS/INDUSTRY: NO
17. FATHER'S NAME (First, Middle, Last): John Mullin
18. MOTHER'S NAME (First, Middle, Maiden Surname): Bermate Johnson
19a. INFORMANT'S NAME (Type/Print): Gerald Mullin
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5116 Arbutus Baltimore 21227
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): West View Memorial Park
20c. LOCATION — City or Town, State: Baltimore MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Alethia McClenney
22. NAME AND ADDRESS OF FACILITY: 2302 W North Ave

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. COPD

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Advanced Neurological Disease

DUE TO (OR AS A CONSEQUENCE OF):

c. Advance Cardiac disease

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Marc Klaw
29c. LICENSE NUMBER: D23760
29d. DATE SIGNED (Month, Day, Year): ▶ 4/3/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARKOWITZ M.D 9141 BALTIMORE BLVD LAUREL 20723
31. DATE FILED (Month, Day, Year): APR 4 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

ems 23a thu 28f Per M.E. FilmG652 6/2/89 CG

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11221

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ~~WILLARD~~ Alfred MURRAY | | | 2. DATE OF DEATH: MONTH 4 DAY 8 YEAR 89 | 3. TIME OF DEATH: 3:40 A M |
| 4. SOCIAL SECURITY NUMBER: 212-46-6483 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 42 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8/27/46 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): University Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2016 BRYANT AVENUE | | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): DONALD GAINES MURRAY | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSA WALKER |
| 19a. INFORMANT'S NAME (Type/Print): ROSA MURRAY | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2016 Bryant Avenue, Balto., Md. 21217 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald D Wade | 22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Intracerebal hemorrhage and morphine intoxication | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☒ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 4/8/89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO | 28d. DESCRIBE HOW INJURY OCCURED: Unknown |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Unknown | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Unknown |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Charles P. Kokes MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-8-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn Street, Baltimore, MD 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 24 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

OHMH-16 Rev 1/89

ISSII 89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11222

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): KATHERINE L. MYERS

**2. DATE OF DEATH** (Month, Day, Year): 4 4 89

**3. TIME OF DEATH**: 10 45 AM

**4. SOCIAL SECURITY NUMBER**: 146-18-7478

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 12/25/05

**8. BIRTHPLACE** (State or Foreign Country): MD

**9a. FACILITY NAME** (If not institution, give street and number): HOMEWOOD HOSPITAL CENTER

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTIMORE CITY

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: BALTIMORE CITY

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 11 WEST 20th STREET APT. 14I

**10f. ZIP CODE**: 21218

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No--- if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: BLACK

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN — College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): UNKNOWN

**16b. KIND OF BUSINESS/INDUSTRY**: RETIRED

**17. FATHER'S NAME** (First, Middle, Last): JOSEPH CHANDLER

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): JONE ANNA HARRIS

**19a. INFORMANT'S NAME** (Type/Print): EULEALIA ROBINSON

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3204 INGLESIDE AVENUE/BALTIMORE, MD 21215

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): KING MEMORIAL PARK CEMETERY

**20c. LOCATION — City or Town, State**: RANDALLSTOWN, MD

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Anthony E. Ward Jr.

**22. NAME AND ADDRESS OF FACILITY**: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Seizures | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Brain tumor | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Breast CA | |

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☐ NO

**26. PLACE OF DEATH** (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: D Bocuzzi MD

**29c. LICENSE NUMBER**:

**29d. DATE SIGNED** (Month, Day, Year): ▶ 4/4/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): D Bocuzzi MD

**31. DATE FILED** (Month, Day, Year): APR 6 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11223
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): PERCY A. MYLER | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 2, 1989 | 3. TIME OF DEATH: 10 40 M |
| 4. SOCIAL SECURITY NUMBER: 225-16-1091 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 76 yrs YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8-2-12 | 8. BIRTHPLACE (State or Foreign Country): VA |
| 9a. FACILITY NAME (If not institution, give street and number): Bon Secours Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md 21223 | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore 21223 | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1217 W. Fayette St. | | 10f. ZIP CODE: 21223 | 10g. CITIZEN OF WHAT COUNTRY? US |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 8+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Joseph Myler | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary F Goodwyn |
| 19a. INFORMANT'S NAME (Type/Print): Alice Scott | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1937 N. 24th St Phila PA 19121 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Family Plot | 20c. LOCATION — City or Town, State: Stony Creek Va |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Marshall D Hayes | 22. NAME AND ADDRESS OF FACILITY: Marshall D Hayes F/H 638 N. Gilmor St Balto., Md 21217 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis 2° Massive (L) Pneumonitis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Acute Renal Failure

DUE TO (OR AS A CONSEQUENCE OF):

c. Chronic Obstructive Lung Disease

DUE TO (OR AS A CONSEQUENCE OF):

d. Blind

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

e. History of Neuro Syphillis

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D18711 | 29d. DATE SIGNED (Month, Day, Year) ▶ APRIL 2/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BERNARD D. GRZECH JR MD - 2000 W. BALTIMORE St, Md. 21223 | | |
| 31. DATE FILED (Month, Day, Year): APR 4 1989 | REGISTRAR'S SIGNATURE | |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11224

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): James S. Mitchell | | | 2. DATE OF DEATH (Month, Day, Year): April 3, 1989 | 3. TIME OF DEATH: 8:30P M |
| 4. SOCIAL SECURITY NUMBER: 240-38-7385 | 5. SEX: 1 ☐ M 2 ☐ F (X) | 6. AGE (In yrs. last birthday): 61 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 9-3-27 | 8. BIRTHPLACE (State or Foreign Country): Clinton, N.C. |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 (X) YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2537 Boarman Ave Baltimore, Md | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 (X) Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 (X) NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 (X) NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Lonnie Mitchell | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Hattie Royal |
| 19a. INFORMANT'S NAME (Type/Print): Helen L. Mitchell | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2537 Boarman Ave Balto., Md. 21215 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 (X) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Eastview Memorial Cem. | 20c. LOCATION — City or Town, State: Baltimore |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy O. Dyett | 22. NAME AND ADDRESS OF FACILITY: Leroy O. Dyett Funeral Home, Inc. 4600 Liberty Hghts Ave. 21207 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma of the lung, with metastasis to the brain | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Sepsis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 (X) NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 (X) NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 (X) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 (X) Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 (X) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Patrick K.Y Chau MD | 29c. LICENSE NUMBER: N/A | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/3/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Patrick Chau, M.D. | c/o Maryland General Hospital | |
| 31. DATE FILED (Month, Day, Year): APR 5 1989 | 32. REGISTRAR'S SIGNATURE: for Lenora Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11225

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Millard Lee McGraw
2. DATE OF DEATH: MONTH 4 DAY 10 YEAR 89
3. TIME OF DEATH: 9:15 AM
4. SOCIAL SECURITY NUMBER: 566-03-3802
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 08/23/17
8. BIRTHPLACE (State or Foreign Country): West Virginia

McGraw, L. Millard

9a. FACILITY NAME (If not institution, give street and number): University Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore City

RESIDENCE OF DECEDENT

10a. STATE: West Virginia
10b. COUNTY: Fayette
10c. CITY, TOWN OR LOCATION: Ansted
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: PO Box 283 (Ramsey)
10f. ZIP CODE: 25812
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: World War II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver
16b. KIND OF BUSINESS/INDUSTRY: Mining Company

17. FATHER'S NAME (First, Middle, Last): Norville Orton McGraw
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lara Belle Ramsey

19a. INFORMANT'S NAME (Type/Print): (wife) Cara Helen Kesler McGraw
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Kesler Presbyterian Church Cem.
20c. LOCATION — City or Town, State: Clifty, Fayette Co., W. VA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: David L. Sauers
22. NAME AND ADDRESS OF FACILITY: Capitol Funeral Service, Falls Church, VA

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Sepsis | |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Acute lymphocytic leukemia | 1 mos |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
28. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Maurice A Venator MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 4/10/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M Venator MD

31. DATE FILED (Month, Day, Year): APR 14 1989
32. REGISTRAR'S SIGNATURE: Julia Gardner Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11226
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): McNamara, John V. — MCNAMARA JOHN.

**2. DATE OF DEATH** (Month, Day, Year): 4-9-89

**3. TIME OF DEATH**: 7:10 pm M

**4. SOCIAL SECURITY NUMBER**: 216-03-6349

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 76 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 7-27-12

**8. BIRTHPLACE** (State or Foreign Country): Md.

**9a. FACILITY NAME** (If not institution, give street and number): LIBERTY MEDICAL CENTER

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTIMORE

**9c. COUNTY OF DEATH**: ~~BALT.~~

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md.

**10b. COUNTY**: N/A

**10c. CITY, TOWN OR LOCATION**: Baltimore, Md.

**10d. INSIDE CITY LIMITS?** 1 [X] YES 2 [ ] NO

**10e. STREET AND NUMBER**: Bolton Hill

**10f. ZIP CODE**:

**10g. CITIZEN OF WHAT COUNTRY?**: U. S. A.

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [ ] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: N/A

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: N/A

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): N/A
College (1-4 or 5+): N/A

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Engineer-Notre Dame

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): John McNamara

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Mary Hudson

**19a. INFORMANT'S NAME** (Type/Print): Mrs. Margaret M. Tobin

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3223 Strickland St. - Baltimore, Md. 21229

**20a. METHOD OF DISPOSITION** 4-13-89
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State
4 [ ] Donation 5 [ ] Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): New Cathedral Cemetery;

**20c. LOCATION — City or Town, State**: Baltimore, Md.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ G. Truman Schwab

**22. NAME AND ADDRESS OF FACILITY**: 3512 Frederick Avenue
Baltimore, Md. 21229

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. PNEUMONIA

DUE TO (OR AS A CONSEQUENCE OF):
—

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. _____

DUE TO (OR AS A CONSEQUENCE OF):
—
c. _____

DUE TO (OR AS A CONSEQUENCE OF):
—
d. _____

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [ ] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [X] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Neil Kmmel MD

**29c. LICENSE NUMBER**: D36409

**29d. DATE SIGNED** (Month, Day, Year): ▶ 4/9/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print)

**31. DATE FILED** (Month, Day, Year): APR 11 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 11226

89 11227

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the ___ or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CAROLYN R MERGL
2. DATE OF DEATH — MONTH: 04 DAY: 02 YEAR: 1989
3. TIME OF DEATH: 4.25 A.M
4. SOCIAL SECURITY NUMBER: 218404448
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 47 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 03/05/42
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

**RESIDENCE OF DECEDENT**

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: MIDDLE RIVER
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 9802 TAILSPIN LANE APT. H.
10f. ZIP CODE: 21220
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12YRS. — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CLERK
16b. KIND OF BUSINESS/INDUSTRY: STATE OF MARYLAND
17. FATHER'S NAME (First, Middle, Last): VERNON F. MERGL
18. MOTHER'S NAME (First, Middle, Maiden Surname): ELOISE MAY PAYNE
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GREEN MOUNT
20c. LOCATION — City or Town, State: BALTO., MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Paul F. Evans Jr.
22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF CHIMES 2325 YORK ROAD - TIMONIUM

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory arrest
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. sepsis
DUE TO (OR AS A CONSEQUENCE OF):
c. Rt stump gangrene
DUE TO (OR AS A CONSEQUENCE OF):
d. Grand mal seizure

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: C Xenopoulos M.D. Intern @ GSH
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 04/01/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): XENOPOULOS P. NICHOLAOS 5601 Loch Raven Blvd/GSH Balt. MD 21239
31. DATE FILED (Month, Day, Year): APR/02/1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 11527

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11228
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): NATHAN METZGAR | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 12, 1989 | 3. TIME OF DEATH: 3 P. M |
| 4. SOCIAL SECURITY NUMBER: 215-30-0912 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): NOV. 25, 1901 | 8. BIRTHPLACE (State or Foreign Country): GERMANY |
| 9a. FACILITY NAME (If not institution, give street and number): 2500 W. BELVEDERE AVE, APT. 1101 | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2500 W. BELVEDERE AVE., APT. 1101 | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 6+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER | 16b. KIND OF BUSINESS/INDUSTRY: COMFY COMPANY |
| 17. FATHER'S NAME (First, Middle, Last): UNKNOWN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN | |
| 19a. INFORMANT'S NAME (Type/Print): RICHARD EPPLE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 45 WADE AVE CATONSVILLE, MD 21228 | |
| 20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHEVRA AHAVAS CHESED-RANDALLSTOWN, MD | 20c. LOCATION — City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joel D Lewis | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute congestive failure | Immediate |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. ASCVD | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Deth C Matchar | 29c. LICENSE NUMBER: MD 7000 | 29d. DATE SIGNED (Month, Day, Year): 4/13/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOS C. MATCHAR - 3635 Old Court Rd 21208 | | |
| 31. DATE FILED (Month, Day, Year): APR 18 1989 | 32. REGISTRAR'S SIGNATURE: Julia Freedom-Randall | |

DHMH-15 Rev 1/89

88 11558

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11229

2:30pm

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified immediately.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Agnes Miller — Agnes — Mc Iler
2. DATE OF DEATH: MONTH 4 DAY 2 YEAR 89
3. TIME OF DEATH: 2:30 PM
4. SOCIAL SECURITY NUMBER: 218.18.5789
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 87 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 01/05/02
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTO. MD
9c. COUNTY OF DEATH: City

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: ---------
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 329 South Robinson Street
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5 — College (1-4 or 5+):
15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housework
16b. KIND OF BUSINESS/INDUSTRY: At Home
17. FATHER'S NAME (First, Middle, Last): Lukasczewicz
18. MOTHER'S NAME (First, Middle, Maiden Surname):
19a. INFORMANT'S NAME (Type/Print): Emily Miller
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 329 S. Robinson St. Balto., Md. 21224
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus Cemetery
20c. LOCATION — City or Town, State: Dundalk, Balto. Co., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles G. Zeiler
22. NAME AND ADDRESS OF FACILITY: Charles S. Zeiler & Son Inc. 901 S. Conkling St.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lobar Pneumonia — 1 wk

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Right pleural effusion, Parkinson's Disease, Right pleural effusion, Parkinson's Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Gormley
29c. LICENSE NUMBER: D18587
29d. DATE SIGNED (Month, Day, Year): ▶ 4/3/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul E Gormley 900 Church Hospital Balto. Md

31. DATE FILED (Month, Day, Year): APR 3 1988
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11230
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Thomas R. Mcknight | | 2. DATE OF DEATH (Month, Day, Year): April 12, 1989 | 3. TIME OF DEATH: 3:45PM M |
| 4. SOCIAL SECURITY NUMBER: 217-62-1759 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 40 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9/23/48 |
| 8. BIRTHPLACE (State or Foreign Country): S.C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 526 WEST PRESTON STREET | | 10f. ZIP CODE: 21201 | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☒ YES 2 ☐ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED | 16b. KIND OF BUSINESS/INDUSTRY: NA | |
| 17. FATHER'S NAME (First, Middle, Last): JAMES L. McKNIGHT | 18. MOTHER'S NAME (First, Middle, Maiden Surname): JANIE G. GAMBLE | | |
| 19a. INFORMANT'S NAME (Type/Print): JANIE G. McKNIGHT | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 526 W. PRESTON STREET/BALTIMORE, MD. 21201 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VA. CEMETERY | 20c. LOCATION — City or Town, State: OWINGS MILLS, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William C. March | 22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Intra ventricular hemorrhage
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Sickle Cell disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pronounced brain dead

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: ☒ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: ☒ 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Gregory Lutz, M.D. | 29c. LICENSE NUMBER: n/a | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/12/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gregory E Lutz, MD | c/o Maryland General Hospital | |
| 31. DATE FILED (Month, Day, Year): APR 14 1989 | 32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall | |

DHMH-16 Rev 1/89

88 11530

MCKINNEY, GEORGE W
08/05/35

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11231

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to the as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GEORGE W MCKINNEY | | 2. DATE OF DEATH (Month, Day, Year): APRIL 8, 1989 | 3. TIME OF DEATH: 2:10 P M |
| 4. SOCIAL SECURITY NUMBER: 219 30 2817 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 53 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): June 5, 1935 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: BALTIMORE City | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Middle River | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 403 Crisfield Road | 10f. ZIP CODE: 21220 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): ---- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintenance | 16b. KIND OF BUSINESS/INDUSTRY: General Motors | |
| 17. FATHER'S NAME (First, Middle, Last): James McKinney | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace Hughes | | |
| 19a. INFORMANT'S NAME (Type/Print): Betty McKinney (Wife) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 403 Crisfield Road 21220 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Memorial Gardens | 20c. LOCATION — City or Town, State: Baltimore County, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. 21221 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis | 3 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Lung Cancer | 5 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 1 77

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D. (Resident) | 29c. LICENSE NUMBER: #D37913 | 29d. DATE SIGNED (Month, Day, Year): 4/08/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Louis SALAS 600 Wolfe ST. Balto, Md 21205

31. DATE FILED (Month, Day, Year): 4/08/89 | 32. REGISTRAR'S SIGNATURE: APR 11 1989 Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11232

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CAROLINE SAXTON MILES
2. DATE OF DEATH (Month, Day, Year): 04 03 89
3. TIME OF DEATH: 740A M
4. SOCIAL SECURITY NUMBER: 234-32-5559
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 09/01/100
8. BIRTHPLACE (State or Foreign Country): W. VA.
9a. FACILITY NAME (If not institution, give street and number): FRANCIS Scott KEY Med Ctr
9b. CITY, TOWN OR LOCATION OF DEATH: BALT., Md.
9c. COUNTY OF DEATH: Balt. City

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: ------
10c. CITY, TOWN OR LOCATION: BALT, Md
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5100 Wright AVE
10f. ZIP CODE: 21205
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4 or 5+): ----
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER
16b. KIND OF BUSINESS/INDUSTRY: OWN HOME
17. FATHER'S NAME (First, Middle, Last): THOMAS W. SIMPKINS
18. MOTHER'S NAME (First, Middle, Maiden Surname): JOSIE THOMAS
19a. INFORMANT'S NAME (Type/Print): RAY MILES (SON)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5100 WRIGHT AVE. BALTIMORE, MD. 21205
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brian D. Lewis
22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Home Inc. 3331 Brehms Lane, Balto. Md. 21213

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Massive Intra-cranial Hemorrhage
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M. Al-Lozi — Margit L. Bloecker M.D. — M.D.
29c. LICENSE NUMBER: D23424 — ESK 9193I
29d. DATE SIGNED (Month, Day, Year): ▶ 4/3/89.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margit L. Bloecker MD, FSHMC, 4940 Eastern Ave, Baltimore, Md. 21224
31. DATE FILED (Month, Day, Year): APR 4 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Mumford

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

88 1535

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 11233

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Noah W. Mitchell Jr. | | | | 2. DATE OF DEATH MONTH 4-3-89 DAY YEAR | 3. TIME OF DEATH 10:05AM M |
| 4. SOCIAL SECURITY NUMBER: 216-36-9404 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 47 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8 26 1941 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH | | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1202 E. 36th Street | 10f. ZIP CODE: 21218 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] ND Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Line Work | 16b. KIND OF BUSINESS/INDUSTRY: Auto Mfg. | |
| 17. FATHER'S NAME (First, Middle, Last): Noah W. Mitchell Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucille Wooden | |
| 19a. INFORMANT'S NAME (Type/Print): Lucinda N. Mitchell | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1202 E. 36th St.,Balto.,Md. 21218 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial | 20c. LOCATION — City or Town, State: Balto..Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edison M. Perkins Jr. | | 22. NAME AND ADDRESS OF FACILITY: 4905 York Rd.21212 H.W. Jenkins & Sons Co.,Balto.,Md. | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Hypertensive arteriosclerotic cardiovascular disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO — INSPECTION | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |
| 27. MANNER OF DEATH [X] 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year) ▶ 4-4-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan,M.D. | 111 Penn Street,Baltilmore,MD 21201 | VC |
| 31. DATE FILED (Month, Day, Year): APR 5 1989 | 32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall | |

DHMH-16 Rev 1/89

89 11234

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2-5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): IDELL NIVENS
2. DATE OF DEATH (Month, Day, Year): 4-13-89
3. TIME OF DEATH: 12:10 AM
4. SOCIAL SECURITY NUMBER: 215-28-9348
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 68 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 2/25/21
8. BIRTHPLACE (State or Foreign Country): S.C
9a. FACILITY NAME (If not institution, give street and number): Bon Secours Hospital
9b. CITY, TOWN OR LOCATION OF DEATH:
9c. COUNTY OF DEATH:

**RESIDENCE OF DECEDENT**

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 20 N. Bernice
10f. ZIP CODE: 21229
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) | College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Will Cash
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ella Burch
19a. INFORMANT'S NAME (Type/Print): Ella Wilkins
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20 N. Bernice Ave Balto, Md 21229
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Mem Park
20c. LOCATION — City or Town, State: Arbutus, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: March F. H. West 4300 Wabash Ave

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | upper GI bleeding | |
| DUE TO (OR AS A CONSEQUENCE OF): b. | possible gastritis | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | septicemic shock | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | Congestive Heart failure | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Pulmonary Disease, Moderate ASCVD

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D16263
29d. DATE SIGNED (Month, Day, Year): 4/13/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JUAN A. BELTRAN, 1940 W. BALTIMORE ST. BALT, MD
31. DATE FILED (Month, Day, Year): APR 20 1989
32. REGISTRAR'S SIGNATURE: Julia Dawson-Lindsay 2/22/89

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11235
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROSE NACHLAS | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 20, 1989 | 3. TIME OF DEATH: 2:40 P M |
| 4. SOCIAL SECURITY NUMBER: 212-40-6111 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2-1-97 | 8. BIRTHPLACE (State or Foreign Country): RUSSIA |
| 9a. FACILITY NAME (If not institution, give street and number): 5816 CLOVER RD. | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 5816 CLOVER RD. | | 10f. ZIP CODE: 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced XX | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO XXX Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY: AT HOME |
| 17. FATHER'S NAME (First, Middle, Last): ABRAHAM ISAAC MALMAN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ESTHER UNKNOWN | | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. RAY BECKER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3305 LIGHTFOOT DR. BALTO., MD 21208 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BETH TFILOH | | 20c. LOCATION — City or Town, State: BALTIMORE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CONGESTIVE HEART FAILURE | 1 YEAR |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): HYPERTENSIVE ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE | 10 YEARS |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Marvin Goldstein, MD | D01437 | ▶ APRIL 21, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARVIN GOLDSTEIN, MD 6001 PARK HEIGHTS AVE. BALTO., MD 21215

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 26 1989 | [signature] |

DHMH-16 Rev 1/89

88 11532

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11236

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Elie Nelson | | | | 2. DATE OF DEATH (Month, Day, Year): April 16, 1989 | 3. TIME OF DEATH: 2:55 p.m. |
| 4. SOCIAL SECURITY NUMBER: 251-11-1167 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Nov. 30, 1920 | 8. BIRTHPLACE (State or Foreign Country) |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3724 Flowerton Rd. | | 10f. ZIP CODE: 21229 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): James Nelson | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mattie Nelson |
| 19a. INFORMANT'S NAME (Type/Print): Elease Nelson | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3724 Flowerton Rd. Baltimore, Md. 21229 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Kings Memorial Park | 20c. LOCATION — City or Town, State: Randallstown, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Cecil A Estep | 22. NAME AND ADDRESS OF FACILITY: Estep Brothers Funeral Home P.A. 1300 Eutaw Place | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Colon Cancer with Liver Metastasis (Carcinoma) | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Staphylococcus Septicemia

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Stephen Lopez MD | 29c. LICENSE NUMBER: OH008 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/16/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stephen Lopez c/o: Maryland General Hospital, 827 Linden Ave., Balto., MD 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

Transferred to Dell-Frederick Fun. Home, 1543 Ligonier St., Latrobe, Pa. 15650

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11237

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

8 (9)

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Adeline Noel | | | 2. DATE OF DEATH (Month, Day, Year): April 14, 1989 | 3. TIME OF DEATH: 2:45 p.M |
| 4. SOCIAL SECURITY NUMBER: 183-26-6681 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): September 21, | 8. BIRTHPLACE (State or Foreign Country): 1901 Pa. |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland-General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: Inns of Evergreen South | | 10f. ZIP CODE: 21202 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 1st yr. | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker | 16b. KIND OF BUSINESS/INDUSTRY: home |
| 17. FATHER'S NAME (First, Middle, Last): Frank Noel | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Kistner | |
| 19a. INFORMANT'S NAME (Type/Print): Bob Wickham | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 961 Circle Drive, Baltimore, Md. 21227 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St, Vincent's Cem. Unity Township | 20c. LOCATION — City or Town, State: Westmoreland Co. Pa. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph N. Zannino, Jr. | | 22. NAME AND ADDRESS OF FACILITY: Joseph N. Zannino Funeral Home 263 S. Conkling Street, Balto. 21224 Md. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio Respiratory Arrest | 30 minutes |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Julian A. Kim RESIDENT. | 29c. LICENSE NUMBER: D37171 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/15/89. |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julian Kim, MD c/o: Maryland General Hospital, 827 Linden Ave., Balto., MD 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 18 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

OHMH-16 Rev 1/89

24

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11238

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): VALARIE NORMAN C. | | | | 2. DATE OF DEATH (Month, Day, Year): 4 / 5 / 89 | 3. TIME OF DEATH: 12:05 AM |
| 4. SOCIAL SECURITY NUMBER: 212-604-501 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 35 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 2/20/54 | 8. BIRTHPLACE (State or Foreign Country): Baltimore |
| 9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE MD | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2015 Ridgehill Avenue | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Child Care Worker | 16b. KIND OF BUSINESS/INDUSTRY: Child Care | |
| 17. FATHER'S NAME (First, Middle, Last): Carl Stokes | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eloise Preston | |
| 19a. INFORMANT'S NAME (Type/Print): Delores Stokes | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2002 Presbury St. Baltimor, Md. 21217 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Eastview Memorial Park | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Derrick C. Jones | 22. NAME AND ADDRESS OF FACILITY: 4611 Park Heights Avenue | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CRYPTOCOCCAL MENINGITIS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. RESPIRATORY ARREST

DUE TO (OR AS A CONSEQUENCE OF):
c. RENAL FAILURE

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jerome Dunlap MD Med H.O. | 29c. LICENSE NUMBER: D37203 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-12-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4600 Liberty Heights Rd. Baltimore md 21215 | | |
| 31. DATE FILED (Month, Day, Year): APR 13 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

88 11538

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11239
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Katherine B Novotny
2. DATE OF DEATH: MONTH 4 DAY 18 YEAR 89
3. TIME OF DEATH: 12:25 AM
4. SOCIAL SECURITY NUMBER: 216-14-0654
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 95 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 10/1/1893
8. BIRTHPLACE (State or Foreign Country): AMRYLAND
9a. FACILITY NAME (If not institution, give street and number): Belair Convelesarium
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: CARNEY
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3206 SUMMIT AVE.
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY? U.S.A
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES X
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3 YEARS College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOME MAKER
16b. KIND OF BUSINESS/INDUSTRY:
17. FATNER'S NAME (First, Middle, Last): MATTHEW NOVOTNY
18. MOTNER'S NAME (First, Middle, Maiden Surname): SOPHIA DVORAK
19a. INFORMANT'S NAME (Type/Print): JOSEPHINE PATRO
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3206 SUMMIT AVE BALTIO. MD 21234
20a. METNOD OF DISPOSITION: X 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HOLY REDEEMER 4/20/1989
20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Paul DeMidovanni
22. NAME AND ADDRESS OF FACILITY: LEONARD J. RUCK INC. 5305 HARFORD RD.BALTIO. MD. 21214

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE CORONARY OCCLUSION

DUE TO (OR AS A CONSEQUENCE OF): SEVERE ARTERIOSCLEROTIC

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF): CAROID VASCULAR D'S

c. DUE TO (OR AS A CONSEQUENCE OF):

d. DIABETES MELLITUS

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA CA OF CERVIX

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D083440
29d. DATE SIGNED (Month, Day, Year) ▶ 4/20/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 5719 HARFORD RD BALTO MD

31. DATE FILED (Month, Day, Year): APR 21 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Lindsay

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

5

89 1239

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11240
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOSEPH W. NICKEL | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 16 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 213-34-8374 | 5. SEX: 1 [X] M 2 [ ] F | 8. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Aug. 21 1937 | 6. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): 6012 Cedonia Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: ----- |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md. | 10b. COUNTY: ---- | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 6012 Cedonia Avenue | | 10f. ZIP CODE: 21206 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Peacetime | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Iron Worker | | 16b. KIND OF BUSINESS/INDUSTRY: Steel Industry |
| 17. FATHER'S NAME (First, Middle, Last): William Nickel | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine -- | | |
| 19a. INFORMANT'S NAME (Type/Print): Diane Nickel (wife) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6012 Cedonia Ave. Balto. Md. 21206 | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Security Process | | 20c. LOCATION — City or Town, State: Baltimore Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Eugene J. Lentz Jr. | | 22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Balto. Md. 21213 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Metastatic Lung Carcinoma | 4 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. | Brain Metastasis | |
| DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [ ] NO ? | 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Marvin I. Feldman MD | D07430 | ▶ 4/18/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Marvin Feldman — Mercy Medical Center

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 20 1989 | Julia Pendon-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11241
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): NARVELL E. NINES | | | 2. DATE OF DEATH (Month, Day, Year): 4 - 11 - 89 | 3. TIME OF DEATH: 431 A M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12-19-1907 | 8. BIRTHPLACE (State or Foreign Country): W. Va. |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor View Med. Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: — | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: — | 10c. CITY, TOWN OR LOCATION: Balto. City | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 102 N. Lenwood Ave | 10f. ZIP CODE: Balto. 21224 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+): — | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer | 16b. KIND OF BUSINESS/INDUSTRY: National Brewery |
| 17. FATHER'S NAME (First, Middle, Last): unknown | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Agnes ? | |
| 19a. INFORMANT'S NAME (Type/Print): Janet DeClavio | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 102 N. Lenwood Ave. Balto. 21224 | |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Memorial Cemetery | 20c. LOCATION — City or Town, State: Belair Rd - Balto. Co. Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John J. Conan & Son, Inc. Funeral Home | 22. NAME AND ADDRESS OF FACILITY: John J. Conan & Son, Inc. 901 Hollins St 21223 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. HYPOTENSION | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. HYPOVOLEMIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. ANEMIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: H. Peres MD MEDICAL INTERN | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 4/11/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 8 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia [illegible] |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11242 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 ... may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EDWARD Mark Nitterright ~~NITTERIGHT~~ | | | 2. DATE OF DEATH (Month, Day, Year): 4 16 89 | 3. TIME OF DEATH: 1 A M |
| 4. SOCIAL SECURITY NUMBER: 220-92-1893 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 19 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): May.9,1969 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore City Jail | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: ------- |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: ------- | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 216 Gittings St. | | 10f. ZIP CODE: 21230 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4 or 5+): ------ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): General Laborer | 16b. KIND OF BUSINESS/INDUSTRY: ---- |
| 17. FATHER'S NAME (First, Middle, Last): William R. Nitterright | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Irene Herrera | |
| 19a. INFORMANT'S NAME (Type/Print): Mr.William R.Nitterright | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 517 Munroe Circle,Glen Burnie,Md.21061 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Mem.Park | 20c. LOCATION — City or Town, State: Md. Elkridge,Howard Co. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Shane Savage | 22. NAME AND ADDRESS OF FACILITY: Balto.Md.21230 McCully Funeral Home,130 E.Fort Ave. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hanging | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? X ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) Scene | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 X Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 4-16-89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 X NO | 28d. DESCRIBE HOW INJURY OCCURED: Subject hanged self. |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): building | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Balto. City Jail, Balto., MD |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-16-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn St., Balto., MD 21201 | | |
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Gordon-Landress | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11243
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Alice C. Norman | | | 2. DATE OF DEATH (Month, Day, Year): 4-12-89 | 3. TIME OF DEATH: 7:05PM M |
| 4. SOCIAL SECURITY NUMBER: 220-18-2935 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 73 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 1- -16 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Johns Hopkins Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: none |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md. | 10b. COUNTY: none | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 904 N. Castle Street | | 10f. ZIP CODE: 21205 | | 10g. CITIZEN OF WHAT COUNTRY?: United States |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Negroid |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5 +): unknown | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | 16b. KIND OF BUSINESS/INDUSTRY: none |
| 17. FATHER'S NAME (First, Middle, Last): Grant Barbour | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Melan Grastor | | |
| 19a. INFORMANT'S NAME (Type/Print): Ella Powell | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 633 N. Aisquith Street/Baltimore, Md. 21202 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Calvary Cemetery | | 20c. LOCATION — City or Town, State: Anne Arundal Co, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin B. Scruggs | | 22. NAME AND ADDRESS OF FACILITY: Calvin B. Scruggs Funeral Home 1412 E. Preston Street/ Balto. Md. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Neck injuries | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES ☒ NO |
| INSPECTION | |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 1-27-89 | M | 1 ☐ YES 2 ☒ NO | fell down stairs |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 904 Castle Street |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Margarita A. Korell | OCME | 4-13-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn Street, Baltimore, MD 21201

VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 13 1989 | |

DHMH-16 Rev 1/89

89 11543

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11244
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mario MAURICIO Nusen | | | 2. DATE OF DEATH (Month, Day, Year): 4-10-89 | 3. TIME OF DEATH: 11:03AM M |
| 4. SOCIAL SECURITY NUMBER: 219-90-5130 | 5. SEX: XX 1 M 2 F | 6. AGE (In yrs. last birthday): 24 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 9-7-1964 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| 10e. STREET AND NUMBER: 3917 SINCLARE LANE | | 10f. ZIP CODE: 21213 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 X Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) XX YES 2 NO Specify: SPANISH | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10TH GRADE; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DISABILITY | | 16b. KIND OF BUSINESS/INDUSTRY: N/A |
| 17. FATHER'S NAME (First, Middle, Last): EDMUNDO NUSEN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): DOLORES HADEL | | |
| 19a. INFORMANT'S NAME (Type/Print): PEGGY A. HADEL | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7441 HOLABIRD AVENUE BALTIMORE, MARYLAND 21222 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OAK LAWN CEMETERY 4-13-1989 | | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert W. Ruck | | 22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MD 21222 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Peritonitis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Retroperitoneal fosciitis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic intravenous drug use

24a. WAS AN AUTOPSY PERFORMED? XX YES 2 NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 Inpatient 2 XX ER/Outpatient 3 DOA; OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)

27. MANNER OF DEATH: 1 XX Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD

29c. LICENSE NUMBER: OCME

29d. DATE SIGNED (Month, Day, Year): ▶ 4-11-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn Street, Baltimore, MD 21201

VC

31. DATE FILED (Month, Day, Year): APR 20 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11245
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending Physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|
| CHARLES ACHESON O'MALLEY , (JR.) | APRIL 15, 1989 | 2:30 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 067-12-9689 | 1 ☒ M 2 ☐ F | 71 YRS. | | | 8/13/17 | New Jersey |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| THE JOHNS HOPKINS HOSPITAL | BALTIMORE CITY | BALTIMORE |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Florida | | Palm City | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 4322 S.W. Dundee Court | 34990 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | 2 years | Insurance Exec. | Fred S. James, Inc. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Charles A. O',alley, Sr. | Edna Ill |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Nancy B. O'Malley | 4322 S.W. Dundee Court Palm City, Fla. 34990 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Security Process Crematory | Catonsville, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Jackie M. Shannon. | Hubbard Funeral Home, Inc, 4107 Wilkens Avenue Baltimore, Md. 21229 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute myelogenous leukemia | 4 mo. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Mylodysplastic syndrome | 2 yrs. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| MD HOUSESTAFF | (TX)H3616 | ▶ 4-15-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
CHARLTON WILSON M.D. JOHNS HOPKINS HOSPITAL, BALTO. MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 20 1989 | Julia Pendleton-Randall |

DHMH-16 Rev 1/89

89 11245

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11246
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): (Orange, Willia) Willia Orange | | | | 2. DATE OF DEATH: Month April Day 26 Year 1989 | 3. TIME OF DEATH: 4:00 p.m. |
| 4. SOCIAL SECURITY NUMBER: 217 16 0297 | 5. SEX: 1 ☐ M 2 ☒ F XX | 6. AGE (In yrs. last birthday): 69 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1-19-20 | 8. BIRTHPLACE (State or Foreign Country): Ga. |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH | |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: Md. | 10b. COUNTY: none | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 4423 Belvieu Ave. | | 10f. ZIP CODE: 21215 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 th; College (1-4 or 5+): Trade Sch. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Beautician | | 16b. KIND OF BUSINESS/INDUSTRY: Beauty | |
| 17. FATHER'S NAME (First, Middle, Last): David Payne | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Payne | | | |
| 19a. INFORMANT'S NAME (Type/Print): Albert Orange | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4423 Belvieu Ave. Balto., Md. 21215 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest | | 20c. LOCATION — City or Town, State: Owings Mills, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James A. Morton | | 22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons 1701 Laurens Street 21217 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hypoxia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumonia Secondary to Aspiration | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Esophageal Squamous Cell Carcinoma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Liver Cirrhosis, Hypertension, Renal Stenosis, | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Below Knee Amputation, Right Leg, Statuspost Correction Aortic Aneurysm Bilateral Iliac and Carotid Artery Stenosis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | M | 1 ☐ YES 2 ☐ NO | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| James J. Cole M.D. | N/A | 4-26-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. James Cole M.D. C/O Maryland General Hospital

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 1 1989 | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11247

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Paul P. O'Rourke Sr. | | 2. DATE OF DEATH (Month, Day, Year): April 28 1989 | 3. TIME OF DEATH: 12:05 a M |
| 4. SOCIAL SECURITY NUMBER: 215-07-9980 | 5. SEX: 1 ☐ M 2 ☐ F XX | 6. AGE (In yrs. last birthday): 69 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7. DATE OF BIRTH (Month, Day, Year): June, 19, 1919 | 8. BIRTHPLACE (State or Foreign Country): Maryland | | |
| 9a. FACILITY NAME (If not institution, give street and number): 4753 Chatford Ave. | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: ---------- | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: ---------- | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4753 Chatford Avenue | 10f. ZIP CODE: 21206 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5+): n/a | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Superintendent | 16b. KIND OF BUSINESS/INDUSTRY: construction | |
| 17. FATHER'S NAME (First, Middle, Last): Paul P. O'Rourke | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lottie Schneider | | |
| 19a. INFORMANT'S NAME (Type/Print): Hazel O'Rourke | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4753 Chatford Ave. Baltimore, MD 21206 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus | 20c. LOCATION — City or Town, State: Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Curtis Gough | 22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore MD 21213 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARCINOMA of the LUNG | 4 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: J Ardaiz, MD | 29c. LICENSE NUMBER: Md D 408 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4-28-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Ardaiz 7838 Eastern Ave. Baltimore, MD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 1 1989 | 32. REGISTRAR'S SIGNATURE: John Davidson-Randall |

DNMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11248

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Natalie Wollace Oles | | | 2. DATE OF DEATH (Month, Day, Year): 4 13 89 | 3. TIME OF DEATH: 3 50 P M |
| 4. SOCIAL SECURITY NUMBER: 217-18-6726 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9/8/1920 | 8. BIRTHPLACE (State or Foreign Country): BALTO. Co., MD. |
| 9a. FACILITY NAME (If not institution, give street and number): EXTENDED CARE FACILITY UNION MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: — |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: — | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1005 RECTORY LANE | 10f. ZIP CODE: 21211 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 3 YRS. | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TRAVEL AGENT | 16b. KIND OF BUSINESS/INDUSTRY: TRAVEL AGENCY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): FRANK D. WEBB | 18. MOTHER'S NAME (First, Middle, Maiden Surname): NATALIE OUDESLUYS |
| 19a. INFORMANT'S NAME (Type/Print): ADRIENNE OLES | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1005 RECTORY LANE, 21211 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GREEN MT. CREM. | 20c. LOCATION — City or Town, State: BALTO., MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. D. Butts Funeral Home | 22. NAME AND ADDRESS OF FACILITY: HENRY S. TENNEY & SONS STATE ANATOMY BOARD, BALTO., MD. 21201 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Anaplastic carcinoma | 6 mos. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 29f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29e. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Alfred G. Ossman Jr. M.D. | 29c. LICENSE NUMBER: D0 9401 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/13/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Alfred G. Ossman Jr, M.D 1101 St Paul St. Baltimore MD 21202 | | |
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE: MAY 2 1989 Julia Davidson-Randell | |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11249

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EVELYN F. OLSZEWSKI | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 22, 1989 | 3. TIME OF DEATH: 6:00 P. M |
| 4. SOCIAL SECURITY NUMBER: 215-44-0664 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 46 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): FEB. 6, 1943 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 3830 HICKORY AVE. | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3830 HICKORY AVE. | | 10f. ZIP CODE: 21211 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: AT HOME | |
| 17. FATHER'S NAME (First, Middle, Last): ISIDORE RIMSON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): TILLIE KLEIN | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. JAMES OLSZEWSKI | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3830 HICKORY AVE. BALTO., MD 21211 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MIKRO KODESH-BETH ISRAEL CONG. | 20c. LOCATION — City or Town, State: BALTO., MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Sydney L. Stellman | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. METASTATIC COLON CANCER | 1 YR |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Gary I. Cohen MD | 29c. LICENSE NUMBER: D 27730 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/23/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GARY COHEN, MD 711 W. 40TH ST. BALTO. MD 21211

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 27 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

2

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11250
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ANNA LAZETTA OTTO | | | | | 2. DATE OF DEATH (Month, Day, Year): 4/13/89 | 3. TIME OF DEATH: 0530 am M |
| 4. SOCIAL SECURITY NUMBER: 219-20-6651 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 72 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 6/13/16 | 8. BIRTHPLACE (State or Foreign Country): Baltimore, MD |
| 9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: -- | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: -- | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 820 S. CATON AVENUE | | 10f. ZIP CODE: 21229 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last): RAYMOND E. BISHOP | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): HULDA M. JOST | |
| 19a. INFORMANT'S NAME (Type/Print): CATHERINE THERRES | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 917 ROCKHILL AVENUE, BALTIMORE, MD. 21229 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE NATIONAL CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Russell Witzke | | 22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Bronchopneumonia, confluent, diffuse | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Methicillin resistant staph, aureus | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Radiation Fibrosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Endometrial adenocarcinoma

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Michael E Pelczar MD | 29c. LICENSE NUMBER: D09990 | 29d. DATE SIGNED (Month, Day, Year): 4/13/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL E. PELCZAR, M.D. ST. AGNES HOSPITAL, BALTIMORE, MARYLAND

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 24 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 1250

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11251
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Charlotte E. O'Keefe | | | | | 2. DATE OF DEATH: MONTH April DAY 15 YEAR 1989 | | 3. TIME OF DEATH: p M |
| 4. SOCIAL SECURITY NUMBER: 220-44-6876 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 87 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Nov. 20 1901 | | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 6024 Old Harford Road 21214 | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore City | | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 6024 Old Harford Road | | 10f. ZIP CODE: 21214 | | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9Yrs. College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | | 16b. KIND OF BUSINESS/INDUSTRY: | | |
| 17. FATHER'S NAME (First, Middle, Last): Charles A. Black | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary A. Frey | | |
| 19a. INFORMANT'S NAME (Type/Print): M. Christina Suran | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2328 Market St. Camp Hill, Penna. 17011 | | | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral 4/18/89 | | | 20c. LOCATION — City or Town, State: Baltimore, Maryland | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Milton J Knight Jr ▶ Milton J Knight Jr | | 22. NAME AND ADDRESS OF FACILITY: 21214 Leonard J. Ruck, Inc. 5305 Harford Road | | | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute CVA
DUE TO (OR AS A CONSEQUENCE OF):
b. Hypertensive Heart Disease
DUE TO (OR AS A CONSEQUENCE OF):
c. arteriosclerotic vascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 5 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | D 13649 | ▶ 4/17/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Nestor M. Carmona M.D. 6012 Harford Road Baltimore, Maryland

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 20 1989 | Julia Davidson |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11252
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit; pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LEONARD MCKINLEY OVERCASH | | | 2. DATE OF DEATH (Month, Day, Year): 4 17 89 | 3. TIME OF DEATH: 4PM M |
| 4. SOCIAL SECURITY NUMBER: 219-30-4234 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 53 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3/20/36 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Lansdowne | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 3203 Polar Avenue | | 10f. ZIP CODE: 21227 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th grade; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver | | 16b. KIND OF BUSINESS/INDUSTRY: Trucking |
| 17. FATHER'S NAME (First, Middle, Last): Arlie Todd | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel Robertson | | |
| 19a. INFORMANT'S NAME (Type/Print): Kathleen Overcash | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3203 Polar Avenue Baltimore, Md. 21227 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | | 20c. LOCATION — City or Town, State: baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ M. Neal Coleman | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiopulmonary Arrest | 1 hour |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. | Coronary artery disease | 2 years |
| DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): N/A | 28b. TIME OF INJURY: N/A M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO: N/A | 28d. DESCRIBE HOW INJURY OCCURED: N/A |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D29325 (?) | ▶ 4/17/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Grant (Joseph) 3001 S. Hanover St. Baltimore Md

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 20 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 11252

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11253
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUTH M OUTLAW
2. DATE OF DEATH: MONTH 4 DAY 4 YEAR 89
3. TIME OF DEATH: 8:45 A M
4. SOCIAL SECURITY NUMBER: 219-32-1783
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 52 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-1-36
8. BIRTHPLACE (State or Foreign Country): BALTO
9a. FACILITY NAME (If not institution, give street and number): FRANCES SCOTT Key HOSP.
9b. CITY, TOWN OR LOCATION OF DEATH:
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: ~~BALTIMORE~~
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1928 Murry Weiss Ct,
10f. ZIP CODE: 21237
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) ✓ College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): nurses aide
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): UNKNOWN
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mamie Richards
19a. INFORMANT'S NAME (Type/Print): Antoinette L. Harvin
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7206 Jim Rowe Ct. 21237
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Eastview Cemetery
20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James A Morton
22. NAME AND ADDRESS OF FACILITY: James A. Morton& Sons 1701 Laurens St.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASPIRATION Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Anoxic Brain Damage
DUE TO (OR AS A CONSEQUENCE OF):
c. Sudden Death
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Breast CA, MRSA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: AS2664
29d. DATE SIGNED (Month, Day, Year): ▶ 4/4/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRED SHAPIRO, MD 4940 EASTERN Ave.
31. DATE FILED (Month, Day, Year): 4/4/89 APR
32. REGISTRAR'S SIGNATURE: 7 1989 Julia Davidson-Randall

DHMH-16 Rev 1/89

88 11523

1 - FOR STATE REGISTRAR JAMES L. OUSBORNE

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11254
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be signed by the informant and filed with the local registrar as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified before release.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JAMES L. OUSBORNE | | | | 2. DATE OF DEATH (Month, Day, Year): 4/5/89 | 3. TIME OF DEATH: 1910 M |
| 4. SOCIAL SECURITY NUMBER: 212-05-0454 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 89 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): SEPT. 7, 1899 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: --- |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: CATONSVILLE | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 323 LAMBETH ROAD | | 10f. ZIP CODE: 21228 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): OFFICE FOREMAN | 16b. KIND OF BUSINESS/INDUSTRY: C.& P. TELEPHONE CO. | |
| 17. FATHER'S NAME (First, Middle, Last): JACK OUSBORNE | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH | |
| 19a. INFORMANT'S NAME (Type/Print): HELEN OUSBORNE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 323 LAMBETH ROAD, CATONSVILLE, MARYLAND 21228 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HOLY REDEEMER CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Russell Witzke | | 22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CONGESTIVE HEART FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. HYPERTENSION | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. ATRIAL FIBRILLATION. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. RENAL INSUFFICIENCY | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] ND | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] ND |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSEPH QUIST MD. ST AGNES HOSP 900 CATON AVE BALTO MD 21229

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): 4/5/89 | 32. REGISTRAR'S SIGNATURE: APR 6 1989 Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11255

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Snowden, Howard Oscar | 2. DATE OF DEATH: MONTH 4 DAY 2 YEAR 89 | 3. TIME OF DEATH: 8:05 A.M. | |
| 4. SOCIAL SECURITY NUMBER: 214-42-2127 | 5. SEX: 1 [X] M 2 [ ] F | 8. AGE (If yrs. last birthday): 44 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 6/8/44 |
| 8. BIRTHPLACE (State or Foreign Country): | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Liberty M.C. 2600 Liberty Hgts | 9b. CITY, TOWN OR LOCATION OF DEATH: Balto, MD | 9c. COUNTY OF DEATH: MARYLAND | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1601 McKean Ave | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNemployed | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Mack Snowden | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Monroe | | |
| 19a. INFORMANT'S NAME (Type/Print): Cynthia Chambers | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 501 Mt Holly St Balto, Md 21229 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt Zion Cem | 20c. LOCATION — City or Town, State: Balto Co Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph L. Russ | 22. NAME AND ADDRESS OF FACILITY: 3222 W. North Ave Baltimore Md 21216 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulm Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. s/p Line (subclav) Placement.
DUE TO (OR AS A CONSEQUENCE OF):
c. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
d. Encephalopathy

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year): ▶ 4/2/89.

30. NAME AND ADDRESS OF PERSON WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print): EISNER Liberty MED CTR Balt Md

31. DATE FILED (Month, Day, Year): APR 11 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11256
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Bennie S. Oats | | | | | 2. DATE OF DEATH: MONTH 4 DAY 9 YEAR 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 705-12-1798 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 72 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8-13-06 | 8. BIRTHPLACE (State or Foreign Country): N.C. |
| 9a. FACILITY NAME (If not institution, give street and number): (Home) 2544 McHenry ST. 21223 | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: Md. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 2544 McHenry St. | | 10f. ZIP CODE: 21223 | | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | |
| 19a. INFORMANT'S NAME (Type/Print): Glenwood Oats | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3624 Coronado Rd. Baltimore, Md. 21207 | | | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Mem. Park | | | 20c. LOCATION — City or Town, State: Arbutus, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Carl A Estep | | 22. NAME AND ADDRESS OF FACILITY: Estep Brothers Funeral Home P.A. 1300 Eutaw Place | | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive Heart Failure | months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Chronic Obstructive pulmonary Disease | years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| D. Eric Carnell MD | D35695 | ▶ 4.10.89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): D. Eric Carnell, M.D. Univ MD Hosp 22 S Greene St 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 11 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 1256

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11257
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Diane | Emily | Osborne | 4-2-89 | 10:00AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-64-0917 | 1 ☐ M 2 ☒ F | 32 YRS. | | | Oct. 25 1956 | Md. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 1418 Dundalk Avenue | → | Baltimore |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md. | Baltimore | Baltimore | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1418 Dundalk Avenue | 21222 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 11th Grade | n/a | Homemaker | Own Home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Ronford Houchen | Henrietta unknown |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Charlotte Stein | 4418 Kavon Ave., Baltimore, Md. 21206 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Security Process | Baltimore Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Blunt force injuries to head and obstruction of upper airway | |
| | DUE TO (OR AS A CONSEQUENCE OF): XXXXXXXXXXXXXXXXXX by foreign body | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 4-2-89 | 4-2-89 | 1 ☐ YES 2 ☐ NO | Subject beaten |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| home | 1418 Dundalk Avenue |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| MD | OCME | ▶ 4-3-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

vc Charles P. Kokes, M.D. 111 Penn Street, Baltimore, Maryland 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 07 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 11257

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11258
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attend...
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as ... Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ERNA PERRY | | | 2. DATE OF DEATH (Month, Day, Year): 4 - 3 - 89 | 3. TIME OF DEATH: 2:06 PM |
| 4. SOCIAL SECURITY NUMBER: 551-56-0497 | 5. SEX: 1 ☐ M 2 ☒ F XX | 6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2-25-17 | 8. BIRTHPLACE (State or Foreign Country) |
| 9a. FACILITY NAME (If not institution, give street and number): UNION MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 5430 BELAIR RD. | | 10f. ZIP CODE: 21206 | | 10g. CITIZEN OF WHAT COUNTRY? |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 8+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last) | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | |
| 19a. INFORMANT'S NAME (Type/Print): MR. JAMES PERRY | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O.BOX 141, Flint Station, Fall River, Mass. 02723 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 8 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ronald L Wade | | 22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart feilure. List only ona cause on esch lins.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Failure | (at least 2 hours) |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Bilateral Pneumothoracer | (? minutes) |
| | DUE TO (OR AS A CONSEQUENCE OF): c. Asthmatic Attack | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. C.O.P.D. Exacerbation | |

PART II. Other significant conditione contributing to death but not resulting in the underlying cause given in Part I.: No other Past Medical History Known

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF OEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): NA | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. OESCRIBE HOW INJURY OCCUREO: NA |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: David Brian Schnitzer M.D. | 29c. LICENSE NUMBER: NA Intern | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David Brian Schnitzer Union Memorial Hospital Baltimore, MD 21218

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): 4/3/89 | 32. REGISTRAR'S SIGNATURE: MAY 2 1989 Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 11259

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible]. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed [illegible] Director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, [illegible]
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the [illegible] must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ANTHONY JOSEPH PUJIA | | | 2. DATE OF DEATH (Month, Day, Year): MAY 3, 1989 | 3. TIME OF DEATH: 2:36 A M |
| 4. SOCIAL SECURITY NUMBER: N/A | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS 3, DAYS 3 — IF UNDER 24 HRS.: HOURS, MIN. | 7. DATE OF BIRTH (Month, Day, Year): Jan. 30, 1989 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: Edgewood | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 642 Yorkshire Dr. | | 10f. ZIP CODE: 21040 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A | 16b. KIND OF BUSINESS/INDUSTRY: N/A | |
| 17. FATHER'S NAME (First, Middle, Last): Joseph R. Pujia | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eugenia L. Young | |
| 19a. INFORMANT'S NAME (Type/Print): Joseph R. Pujia | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 642 Yorkshire Dr., Edgewood, MD 21040 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. John's Catholic Ch. Cem. | 20c. LOCATION — City or Town, State: Hydes, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. George Altenburg | | 22. NAME AND ADDRESS OF FACILITY: ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary Arrest — DUE TO (OR AS A CONSEQUENCE OF): | - |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Fluid & Electrolyte Imbalance/Renal Failure — DUE TO (OR AS A CONSEQUENCE OF): | 4 days |
| | c. Intractable Pulmonary Effusions/Chylothorax — DUE TO (OR AS A CONSEQUENCE OF): | 30 days |
| | d. Extreme Prematurity | 90 days |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 26d. DESCRIBE HOW INJURY OCCURED | | |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Janet E. Graeber MD. Attending Physician | 29c. LICENSE NUMBER: D27840 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/3/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Janet E. Graeber, M.D. Johns Hopkins Hospital, Dept. of Peds | | |
| 31. DATE FILED (Month, Day, Year): 5/3/89 MAY 4 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Bondale | |

DHMH-16 Rev 1/89

89 1259

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11260
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BERNARD G. PETER SR. | | | 2. DATE OF DEATH (Month, Day, Year): April 19 1989 | 3. TIME OF DEATH: 0830 AM |
| 4. SOCIAL SECURITY NUMBER: 217-07-8969 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8-28-09 | 8. BIRTHPLACE (State or Foreign Country): Nebraska |
| 9a. FACILITY NAME (If not institution, give street and number): UNION MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: N/A |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: N/A | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 110 Enfield Rd. | | 10f. ZIP CODE: 21212 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 5+ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Attorney | 16b. KIND OF BUSINESS/INDUSTRY: Private Practice |
| 17. FATHER'S NAME (First, Middle, Last): Valentine Joseph Peter | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Reese | |
| 19a. INFORMANT'S NAME (Type/Print): Anne P. Hahn | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 30 Woodward Lane Lutherville, Md. 21093 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley | 20c. LOCATION — City or Town, State: Lutherville, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis S Konakis | | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld 6500 York Rd. 21212 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Respiratory failure | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. Chronic Aspiration of blood and secretions | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. Thrombocytopenia and ~~DIC~~ COPD | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

s/p major bowel resection for ischemic bowel.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER: Intern UMH | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-19-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 201 E University Parkway Baltimore MD 21 | | |
| 31. DATE FILED (Month, Day, Year): APR 24 1989 | 32. REGISTRAR'S SIGNATURE: Julia Tricker-Pendarvis | |

DHMH-18 Rev 1/89

89 11260

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11261
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOANNA PINNICK | | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 16, 1989 | 3. TIME OF DEATH: 11:35 P M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 89 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10-12-99 | 8. BIRTHPLACE (State or Foreign Country): N.C. |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTO | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1209 N. CAROLINE St | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ELEMANTARY; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): House wife, | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM WILLIAMS | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ELLA NEWELL |

| | |
|---|---|
| 19a. INFORMANT'S NAME (Type/Print): ELLA M. STOVALL | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3818 CALLAWAY AVE BALTO, Md. 21215 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEM. PK. | 20c. LOCATION — City or Town, State: ARBUTUS . Md |

| | |
|---|---|
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph B. Locke, Jr | 22. NAME AND ADDRESS OF FACILITY: 1304 N. CENTRAL Av. BALTO. Md 21202 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Aspiration pneumonia — Approximate Interval: 10 days
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Congestive heart failure — Approximate Interval: 6 months
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic dementia

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Peter White, Jr. M.D. | 29c. LICENSE NUMBER: D36775 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/17/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Peter White JR Johns Hopkins Hospital

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Pendarvis |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 only is to be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 11261

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11262
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): PETE POGGIOLI | | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 8 89 | 3. TIME OF DEATH: 7:15 PM |
| 4. SOCIAL SECURITY NUMBER: 217-03-6130 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | | 7. DATE OF BIRTH (Month, Day, Year): 9/22/04 | 8. BIRTHPLACE (State or Foreign Country): U.S. MD. |
| 9a. FACILITY NAME (If not institution, give street and number): CHURCH HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: | |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: MD. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTO. MD. 320 S. ALBERMARLE ST | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 320 S. ALBERMARLE ST. | | 10f. ZIP CODE: 21202 | | 10g. CITIZEN OF WHAT COUNTRY? U.S. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TILE SETTER | | 16b. KIND OF BUSINESS/INDUSTRY: CONSTRUCTION | |
| 17. FATHER'S NAME (First, Middle, Last): JOHN POGGIOLI | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): EMMA ARANCI POGGIOLI | | | |
| 19a. INFORMANT'S NAME (Type/Print): PETE POGGIOLI | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 911 EASTERN AVE 21202 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARDENS OF FAITH | | 20c. LOCATION — City or Town, State: BALTO MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: DeHAVEN & SONS 322 S. HIGH ST. 21202 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. METHICILLIN RESISTANT STAPHYLOCOCCAL SEPSIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. EMACIATION

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Mohd B. Yousef | | ▶ |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Church hospital 100 N. broadway Street baltimore Md. 21231

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 11 1989 | [signature] |

DHMH-16 Rev 1/89

89 11262

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11263
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WALLACE L. POOLE, SR. | | | 2. DATE OF DEATH (Month, Day, Year): 04 13 89 | 3. TIME OF DEATH: 540A M |
| 4. SOCIAL SECURITY NUMBER: 213-07-5150 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 85 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1 11 1904 |
| 8. BIRTHPLACE (State or Foreign Country): N. CAROLINA | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1911 WALBROOK AVENUE | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): STEEL WORKER | 16b. KIND OF BUSINESS/INDUSTRY: BETHLEHEM STEEL | |
| 17. FATHER'S NAME (First, Middle, Last): JEFF POOLE | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ROXIE BOWMAN | | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. GLADYS A. POOLE | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1911 WALBROOK AVENUE, BALTIMORE, MD. 21217 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK | 20c. LOCATION — City or Town, State: BALTIMORE, CO., MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Herbert E. Nutter | 22. NAME AND ADDRESS OF FACILITY: NUTTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardio respiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

C H F
Chronic renal failure

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/13/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Samar Saki MD 405 Eden Run Pl Apt K Balt MD | | |
| 31. DATE FILED (Month, Day, Year): APR 21 1989 Julia | 32. REGISTRAR'S SIGNATURE: Gordon Randall | |

DNMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11264
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Nelson F. Pryor, Jr | | | 2. DATE OF DEATH (Month, Day, Year): 4-15-89 | 3. TIME OF DEATH: 6:10PM M |
| 4. SOCIAL SECURITY NUMBER: 212-15-6728 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 18 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4 14 1971 | 8. BIRTHPLACE (State or Foreign Country): Md |
| 9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2900 Woodland Avenue | | 10f. ZIP CODE: 21215 | | 10g. CITIZEN OF WHAT COUNTRY? U S A |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student | | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): Nelson F. Pryor, Sr | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Yvonne Gaines | | |
| 19a. INFORMANT'S NAME (Type/Print): Nelson F. Pryor, Sr | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2900 Woodland Avenue Baltimore, Md 21215 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veteran Cem | | 20c. LOCATION — City or Town, State: Owings Mills, Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the moda of dying, auch as cardiac or reapiratory arrest, shock, or heart failure. List only ona cause on aach line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Pneumonia and asthma
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hunter's syndrome

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO — INQUIRY

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ 4-21-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARGARITA A. KORELL,M.D. 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year): APR 21 1989
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

89 11264

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11265
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Charlie PUGH | | | | | 2. DATE OF DEATH: MONTH 04 DAY 14 YEAR 89 | | 3. TIME OF DEATH: 8:15 AM |
| 4. SOCIAL SECURITY NUMBER: 250-30-3944 (~~250-30-3944~~) | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 65 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 090723 | | 8. BIRTHPLACE (State or Foreign Country): S. Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): U. of MD Med. Syst. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md | | | 9c. COUNTY OF DEATH | |
| **RESIDENCE OF DECEDENT** | | | | | | | |
| 10a. STATE: MD | 10b. COUNTY: Baltimore City | | 10c. CITY, TOWN OR LOCATION: Baltimore | | | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 2503 W. Fairmount Ave | | | 10f. ZIP CODE: 21223 | | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction | | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Willie PUGH | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSA Martin | | | | |
| 19a. INFORMANT'S NAME (Type/Print): B. Robinson MD | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): ~~120~~ 22 S Greene Balto md 21201 | | | | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Kings Memorial Rd | | | 20c. LOCATION — City or Town, State: Balto, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Linette K. Jones | | | 22. NAME AND ADDRESS OF FACILITY: Brown-Thompson F.H. P.O. Box 1433 | | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Metastatic Lung dis. SQ cell | 2 mo.s |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Esophageal CA met. to Lungs | 1 1/2 yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Gross hemoptysis | 2 mo.s |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| B Robinson MD Intern | | ▶ 4/14/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 22 S. Greene St. Balto, Md

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 18 1989 | Julia Davidson-Randall |

DHMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11266
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): AGNES M. PARKS

**2. DATE OF DEATH** (Month, Day, Year): 4 29 89

**3. TIME OF DEATH**: 2:00 P M

**4. SOCIAL SECURITY NUMBER**: 215-09-0347

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 74 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 7-24-1914

**8. BIRTHPLACE** (State or Foreign Country): Baltimore, MD.

**9a. FACILITY NAME** (If not institution, give street and number): GOOD SAMARITAN HOSP

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTIMORE Md.

**9c. COUNTY OF DEATH**: Baltimore City

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: BALTIMORE Md

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 4502 LASALLE AVE

**10f. ZIP CODE**: 21206

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 8th
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Home Maker

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): John GEorge Klein

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Margaret V. Minderlein

**19a. INFORMANT'S NAME** (Type/Print): James E. Parks Sr.

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4502 LaSAlle Aven-Balto. Md.-21206

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Holy REdeemer Cemetery

**20c. LOCATION — City or Town, State**: Baltimore, Maryland

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Kathleen M. Murphy

**22. NAME AND ADDRESS OF FACILITY**: John C. Miller, Inc. 6415 Belair Road Baltimore, Md.-21206

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | 1. ASPIRATION - AF - CHF - ANGINA | 3 DAYS |
| DUE TO (OR AS A CONSEQUENCE OF): | a. CARDIAC ARREST & RESUSSITATION | 9 YRS |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): | 2. CEREBRAL THROMBOSIS - RT CEREBRAL HEMISPHERE | 18 YRS |
| | 3. CA OF BREAST BILATERAL MASTECTOMY | |

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: RT RIB Fx DUE TO ACC 3/25/89

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☒ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year): 3/25/89

**28b. TIME OF INJURY**: PM

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☒ NO

**28d. DESCRIBE HOW INJURY OCCURED**: MALFUNCTION OF CAR ↓ OUT OF CONTROL INTO CURB

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify): STREET

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State): MT VISTA Rd & BELAIR Rd.

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Donald W. Mintzer M.D.

**29c. LICENSE NUMBER**: D07296

**29d. DATE SIGNED** (Month, Day, Year): ▶ 4/29/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): DONALD W. MINTZER 3009 EVERGREEN AVE BALTIMORE MD 21211

**31. DATE FILED** (Month, Day, Year): MAY 1 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 11266

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11267

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH W. PARKER | | | 2. DATE OF DEATH (Month, Day, Year): 4 - 29 - 89 | 3. TIME OF DEATH: 9:48 A M |
| 4. SOCIAL SECURITY NUMBER: 216-03-2315 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10-25-00 | 8. BIRTHPLACE (State or Foreign Country): Md |
| 9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2421 Huron St | | 10f. ZIP CODE: 21230 | 10g. CITIZEN OF WHAT COUNTRY? |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) |
| | | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Thomas Wheatley | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Chambers |
| 19a. INFORMANT'S NAME (Type/Print): Warren Parker | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2336 Ivy |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Mem Park | 20c. LOCATION — City or Town, State: Arbutus, Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dale March | 22. NAME AND ADDRESS OF FACILITY: March F. H. West 4300 Wabash Ave | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASPIRATION PNEUMONIA

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. PA PARKINSON'S DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: RENAL CELL CA

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph Schwartz | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/29/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSEPH SCHWARTZ 301 ST. PAUL R. BALT. Md. 21202

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 1, 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Reynolds |

DHMH-16 Rev 1/89

89 11267

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11268
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be given to the family as the burial-transit permit.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| JOSEPHINE | PIERCE | APRIL 24, 1989 | 8:45 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-74-7022 | 1 ☐ M 2 ☑ F | 78 YRS. | | | 9-28-10 | Va. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| THE JOHNS HOPKINS HOSPITAL | BALTIMORE CITY | BALTIMORE |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md. | | Baltimore | 1 ☑ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 2636 Beryl Ave. Baltimore, Md. | 21213 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☑ NO | 1 ☐ YES 2 ☑ NO Specify: | Specify: Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12. | | Homemaker | At Home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Joseph Chapman | Mahalia Chapman |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Doris Pierce | 2636 Beryle Ave Balto. Md. 21213 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | Arbutus Memorial Park | Baltimore, Md |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Randolph J. Collick | Collick Funeral Home 2431 E. Oliver St. Balto. Md. 21213 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary Arrest | 5 min |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

Adenocarcinoma - unknown Primary

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| S O'Day MD | | ▶ 4/24/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Steven J. O'Day Johns Hopkins Hospital

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 27 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 11268

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11269
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached and used as the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MACK S. PERKINS | | 2. DATE OF DEATH (Month, Day, Year): APRIL 21, 1989 | 3. TIME OF DEATH: 6:50 P M |
| 4. SOCIAL SECURITY NUMBER: 247-30-5339 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10-23-23 |
| 8. BIRTHPLACE (State or Foreign Country): S.C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 723 EAST BIDDLE STREET | 10f. ZIP CODE: 21202 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SPARROW POINT-STEEL SIDE | 16b. KIND OF BUSINESS/INDUSTRY: BETHLEHEM STEEL | |
| 17. FATHER'S NAME (First, Middle, Last): JUNIOR PERKINS | 18. MOTHER'S NAME (First, Middle, Maiden Surname): NORA MALOMAX | | |
| 19a. INFORMANT'S NAME (Type/Print): BETTY COOPER | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 723 EAST BIDDLE STREET/BALTIMORE, MD. 21202 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VA. CEMETERY | 20c. LOCATION — City or Town, State: OWINGS MILLS, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vanessa Davis | 22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE | | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis | 5 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Septic arthritis | 1 month |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Pneumonia | 1 month |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 26d. DESCRIBE HOW INJURY OCCURED | | |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Earl Hope MD | 29c. LICENSE NUMBER: | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/21/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Earl Hope MD Johns Hopkins Hospital Balt MD 21205 | | |
| 31. DATE FILED (Month, Day, Year): APR 26 1989 | 32. REGISTRAR'S SIGNATURE: Julia Denson-Landers | |

DHMH-16 Rev 1/89

89 1129

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11270
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page(s) 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Nettie F. Parker | | | | 2. DATE OF DEATH (Month, Day, Year): 4-22-89 | 3. TIME OF DEATH: 9:21AM M |
| 4. SOCIAL SECURITY NUMBER: 213-12-8944 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 88 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 2-20-01 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): 3154 Ravenwood | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3154 RAVENWOOD AVENUE | | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOMESTIC | 16b. KIND OF BUSINESS/INDUSTRY: RETIRED | |
| 17. FATHER'S NAME (First, Middle, Last): HENRY FOSTER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): HENRIETTA | |
| 19a. INFORMANT'S NAME (Type/Print): SHIRLEY TATUM | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3154 RAVENWOOD AVENUE/BALTIMORE, MD. 21213 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE NATIONAL VA. CEM | 20c. LOCATION — City or Town, State: BALTIMORE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Calvin L. Williams | | 22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO — INQUIRY | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 25. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A. Korell | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-22-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. — 111 Penn Street, Baltimore, MD 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 26 1989 | 32. REGISTRAR'S SIGNATURE: Julia Tiedemann Rudasill |

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DHMH-16 Rev 1/89

89 11270

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11271
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CAROL PERRERA | | 2. DATE OF DEATH (Month/Day/Year): 4/20/89 | 3. TIME OF DEATH: 11:40 P M |
| 4. SOCIAL SECURITY NUMBER: 155-44-3951 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 54 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4-12-35 |
| 8. BIRTHPLACE (State or Foreign Country): N.J. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 919 FAWN ST | 9b. CITY, TOWN OR LOCATION OF DEATH: CITY BALTO MD 21202 | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTO MD. | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 919 FAWN ST | 10f. ZIP CODE: 21202 | 10g. CITIZEN OF WHAT COUNTRY: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CLERK | 16b. KIND OF BUSINESS/INDUSTRY: OFFICE-ELECTIONS |
| 17. FATHER'S NAME (First, Middle, Last): Michael V. IAFELICE | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CATHERINE SHARPE | |
| 19a. INFORMANT'S NAME (Type/Print): Joseph Perrera | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 919 FAWN ST BALTO 21202 | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith | 20c. LOCATION — City or Town, State: BALTO MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Della Noce & Sons Funeral Home | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Complete atelectasis of the left lung | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Adenocarcinoma of the lung | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Cerebral metastases, COPD, Hypertension, Seizure disorder, Asthmatic bronchitis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D30631 | 29d. DATE SIGNED (Month, Day, Year): 4/21/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A ALAN REISINGER MD 5411 OLD FREDERICK RD | | |
| 31. DATE FILED (Month, Day, Year): MAY 01 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

89 11271

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11272
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate should be completed by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY L. POWLEY
2. DATE OF DEATH (Month, Day, Year): APRIL 25, 1989
3. TIME OF DEATH: 6:55 P M
4. SOCIAL SECURITY NUMBER: 233-30-5886
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-11-1921
8. BIRTHPLACE (State or Foreign Country): W. Virginia
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3716 E. Lombard Street
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 11th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
15b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Harrison Oldaker
16. MOTHER'S NAME (First, Middle, Maiden Surname): Cressie Schaeffer
19a. INFORMANT'S NAME (Type/Print): Mr. Linwood G. Powley
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3716 E. Lombard Street 21224 Balto. Md.
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oaklawn Cemetery
20c. LOCATION — City or Town, State: Baltimore Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph N. Zannino Jr.
22. NAME AND ADDRESS OF FACILITY: Joseph N. Zannino Jr. Funeral Home 263 S. Conkling Street 21224

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Midbrain herniation | 6 hr |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Left hemisphere stroke | 48 hr |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Carotid artery atherosclerosis | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
25c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
25e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
25f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Peter White Jr. M.D.
29c. LICENSE NUMBER: D36775
29d. DATE SIGNED (Month, Day, Year): ▶ 4/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Peter White Jr Johns Hopkins Hospital
31. DATE FILED (Month, Day, Year): APR 27 1989
32. [illegible]

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11273

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Everett R. Parker JR. | | | 2. DATE OF DEATH (Month, Day, Year): April 25 1989 | 3. TIME OF DEATH: 12:18 P M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 7 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 8/12/81 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Johns Hopkins Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore City |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Baltimore City | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 914 Stricker St. | 10f. ZIP CODE: 21230 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 2nd; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): STUDENT(CHILD) | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): EVERETT R. PARKER SR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): REGINA FOSTER | |
| 19a. INFORMANT'S NAME (Type/Print): REGINA FOSTER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 914 N. STRICKER STREET (21230) | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. CALVARY CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lynette K. Jones | | 22. NAME AND ADDRESS OF FACILITY: BROWN-THOMPSON F.H. P.O. BOX 4433(21223) | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Neuroblastoma | 18 mo |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: B. J. Corden MD | 29c. LICENSE NUMBER: D23052 | 29d. DATE SIGNED (Month, Day, Year): 4/25/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S. Wondisheu MD Johns Hopkins Hospital 21212 | | |
| 31. DATE FILED (Month, Day, Year): APR 28 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11274 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page [illegible] by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, [illegible] detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Franklin J. Price | | | 2. DATE OF DEATH (Month, Day, Year): 4-12-89 | 3. TIME OF DEATH: 5:15PM M |
| 4. SOCIAL SECURITY NUMBER: 214-96-3570 | 5. SEX: 1 [X] M 2 [ ] F | 5. AGE (In yrs. last birthday): 24 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): Oct. 11, 1964 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 3120 St. Paul Street | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: Baltimore City |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Silver Spring | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1001 Cannon Road | | 10f. ZIP CODE: 20904 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): yes; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student | 16b. KIND OF BUSINESS/INDUSTRY: School | |
| 17. FATHER'S NAME (First, Middle, Last): Franklin J. Price | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Jadwiga Horbaczewski | |
| 19a. INFORMANT'S NAME (Type/Print): Jadwiga Price | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1001 Cannon Road, Silver Spring, Md. 20904 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | 20c. LOCATION — City or Town, State: Silver Spring, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael J. Zimmer | | 22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home 11800 N.H. Avenue, Silver Spring, Md. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Contact gunshot wound of left side of head | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 4-12-89 | 28b. TIME OF INJURY: 5:15PM | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: self inflicted |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 3120 St. Paul Street |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita Korell | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-13-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn Street, Baltimore, MD 21201 vc

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 14 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11275

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARGARET PRICE | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 21, 1989 | 3. TIME OF DEATH: 4 P.M. |
| 4. SOCIAL SECURITY NUMBER: 213-62-5200 | 5. SEX: 1 ☐ M 2 ☒ F | 8. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): May 23, 1925 | 8. BIRTHPLACE (State or Foreign Country): Maryland, AAC. |
| 9a. FACILITY NAME (If not institution, give street and number): 2300 EUTAW PLACE | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Maryland | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE, MARYLAND | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2300 EUTAW PLACE, BALTIMORE, MARYLAND APT-6 | | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Williams Price | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Maggie Anderson | |
| 19a. INFORMANT'S NAME (Type/Print): BESSIE HARRIS | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 APT 6 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery, | 20c. LOCATION — City or Town, State: Lansdowns, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: ESTEP BROTHERS FUNERAL SERVICE, P.A. 1300 EUTAW PLACE, BALTIMORE, MD. 21217 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. loss Ca of the Pancreas. — 8 to 10 weeks.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Malnutrition & Chronic Alcoholism
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Gulab M. Shah MD | 29c. LICENSE NUMBER: D26750 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/24/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. GULAB M. SHAH MD 2105 N. Charles St BALTIMORE 21218

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 25 1989 | 32. REGISTRAR'S SIGNATURE: [signature] |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11276

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): PIERRE HOLLOWAY PINKETT | | | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 6, 1989 | 3. TIME OF DEATH: 7:15A M |
| 4. SOCIAL SECURITY NUMBER: 216-84-5680 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 19 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 6/28/69 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Wicomico | 10c. CITY, TOWN OR LOCATION: Salisbury | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: Rt. #2, Jersey Road | 10f. ZIP CODE: 21801 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: [X] 1 Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black American |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): disabled | 16b. KIND OF BUSINESS/INDUSTRY: n/a | |
| 17. FATHER'S NAME (First, Middle, Last): Fred Cottman | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eugenie Pinkett | | |
| 19a. INFORMANT'S NAME (Type/Print): Eugenie Pinkett Green | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 319 North Poplar Avenue - Salisbury, MD 21801 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Springhill Memory Gardens | 20c. LOCATION — City or Town, State: Hebron, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Patricia Jolley Lashley | 22. NAME AND ADDRESS OF FACILITY: Jolley Memorial Chapel - Rt. #2, Box 920 Jersey Road - Salisbury, Maryland 21801 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiorgan failure | 3 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Adult Respiratory Syndrome | 7 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Congenital Heart Disease | Years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) Error 4-6-89 | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| MD | D35937 | ▶ 4-6-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John M Parker JHH 601 N Wolfe St Balto, MD 21205

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 13 '89 | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11277
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit (see pages 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Raymond Province | | | 2. DATE OF DEATH (Month, Day, Year): April 30, 1989 | 3. TIME OF DEATH: 13:57 pm M |
| 4. SOCIAL SECURITY NUMBER: 282-18-9185 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 66 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 10-11-22 | 8. BIRTHPLACE (State or Foreign Country): France |
| 9a. FACILITY NAME (If not institution, give street and number): Chruch Hospital Corporation | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3334 E. Baltimore Street | | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Rubber manufacturing | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): Kenneth Province | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Renee Salze | |
| 19a. INFORMANT'S NAME (Type/Print): Emma Province | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3334 East Baltimore Street/Balto. MD 21224 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest | 20c. LOCATION — City or Town, State: Baltimore, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Roland P. Moran D | 22. NAME AND ADDRESS OF FACILITY: John A. Moran Funeral Home 3000 E. Baltimore St./Balto. MD 21224 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reapiretory arreat, ahock, or heart feilure. List only one cause on each lina.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Pneumonia | days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

alcoholic liver disease with coagulopathy
Alcoholic Liver Disease with Coagulopathy

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Timothy J. Low | 29c. LICENSE NUMBER: MD D24034 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/30/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Timothy J. Low, M.D. Church Hospital / Timothy Low M.D. | | |
| 31. DATE FILED (Month, Day, Year): MAY 2 _ 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

3H

OHMH-16 Rev 1/89

89 1127

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11278

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit ... Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Gordon Payne | | | | 2. DATE OF DEATH: MONTH 4-27-89 DAY YEAR | 3. TIME OF DEATH: 12:45PM M |
| 4. SOCIAL SECURITY NUMBER: 219-50-0290 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 22 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8-7-66 | 8. BIRTHPLACE (State or Foreign Country): Balto.Md. |
| 9a. FACILITY NAME (If not institution, give street and number): McKean and Baker Streets | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore, City | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1612 N. Pulaski Street Balto., Md. | 10f. ZIP CODE: 21216 | | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY: Marriott Food Service | |
| 17. FATHER'S NAME (First, Middle, Last): Gordon D. Payne , Jr | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Deborah Thomas | | |
| 19a. INFORMANT'S NAME (Type/Print): Deborah Hamber | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1612 N. Pulaski Street Balto., Md. 21216 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Western Star Cem | 20c. LOCATION — City or Town, State: Baltimore | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy O. Dyett | 22. NAME AND ADDRESS OF FACILITY: Leroy O. Dyett & Son Funeral Home 4600 Liberty Hghts Ave Balto, Md 21207 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Gunshot wound of chest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [XX] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [XX] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [XX] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [XX] Other (Specify) street | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [XX] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) 4-27-89 | 28b. TIME OF INJURY 12:40P | 28c. INJURY AT WORK? 1 [ ] YES 2 [XX] NO | 28d. DESCRIBE HOW INJURY OCCURED: Subject shot |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): street | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): McKean & Baker Streets |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [XX] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 4-28-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin,M.D. 111 Penn Street,Baltimore,MD 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

3

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89-11279

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached by the funeral director and the burial-transit permit, Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): KATHERINE PAFFORD | | 2. DATE OF DEATH (Month, Day, Year): 4-19-89 | 3. TIME OF DEATH: 6:35 A M |
| 4. SOCIAL SECURITY NUMBER: 213-12-3178 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3-15-15 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 8115 MURRAY POINT CT | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd; College (1-4 or 5+): None | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Salesperson | 16b. KIND OF BUSINESS/INDUSTRY: Procter& Gamble Company | |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Schriefer | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Francis Plummer | | |
| 19a. INFORMANT'S NAME (Type/Print): Dolores Upperman | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 418 6th Ave. N.E. Glen Burnie, MD 21061 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt Carmel Cemetery | 20c. LOCATION — City or Town, State: Baltimore City, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert Bruce Burch | 22. NAME AND ADDRESS OF FACILITY: Kirkley Funeral Home, 421 Crain Hwy. S. E. Glen Burnie, MD 21061 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, DF complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, DF heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CEREBROVASCULAR ACCIDENT DUE TO ISCHEMIC INFARCT | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ARTERIORSCLEROTIC CARDIOVASCULAR DISEASE; CHRONIC OBSTRUCTIVE PULMONARY DISEASE

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Chi-Shiang Chen M.D. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-19-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHEN, CHI -SHIANG 100 N. BROADWAY BALTIMORE, MD. 21231 | | |
| 31. DATE FILED (Month, Day, Year): APR 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landers | |

DHMH-18 Rev 1/89

89 11280

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): NETTIE M. PATTERSON | | | 2. DATE OF DEATH (Month, Day, Year): 4 / 12 / 89 | 3. TIME OF DEATH: 11 15 AM |
| 4. SOCIAL SECURITY NUMBER: 220-44-9398 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 95 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 1/24/1894 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore city | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Arbutus | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 4700 Gateway Terrace | | 10f. ZIP CODE: 21227 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Operator | 16b. KIND OF BUSINESS/INDUSTRY: Telephone Co. | |
| 17. FATHER'S NAME (First, Middle, Last): Jeremiah Middleton | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Ophilia Jones | |
| 19a. INFORMANT'S NAME (Type/Print): M. Lee Winkel | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 532 W. University Parkway Baltimore, Md. 21210 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Teresa L Goff | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiretory srrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Terminal Colon cA
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Hyper Hyroidism
DUE TO (OR AS A CONSEQUENCE OF):
c. Osteoporosis
DUE TO (OR AS A CONSEQUENCE OF):
d. Anemia

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: CRKMA, Resident | 29c. LICENSE NUMBER: AS24385 28 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/12/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 900 Caton Ave. Baltimore, MD 21229. ST. Agnes Hospital | | |
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | REGISTRAR'S SIGNATURE: Julia Denborn-Kimbark | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11281
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James H. Profit
2. DATE OF DEATH (Month, Day, Year): 4-22-89
3. TIME OF DEATH: 1:15PM M
4. SOCIAL SECURITY NUMBER: 217-12-7865
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 64 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9 9 1924
8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 612 N. Denison Street
10f. ZIP CODE: 21229
10g. CITIZEN OF WHAT COUNTRY? U S A
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Sandy Profit
18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth (Fowles) Fowlkes
19a. INFORMANT'S NAME (Type/Print): Evon Profit Ruffin
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3525 Essex Road Baltimore, Md 21207
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park
20c. LOCATION — City or Town, State: Arbutus, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dale March
22. NAME AND ADDRESS OF FACILITY: March F/H West, 4300 Wabash Avenue

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Arteriosclerotic cardiovascular disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO — INSPECTION
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: [X] 1 Inpatient 2 ER/Outpatient 3 DOA — OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)
27. MANNER OF DEATH: [X] 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A. Korell
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ 4-23-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn Street, Baltimore, MD 21201 vc
31. DATE FILED (Month, Day, Year): APR 27 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

5

89 11281

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11282

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHANNA EVA PARKS
2. DATE OF DEATH (Month, Day, Year): APRIL 15 1989
3. TIME OF DEATH: 2 A. M
4. SOCIAL SECURITY NUMBER: 220-22-8423
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)
7. DATE OF BIRTH (Month, Day, Year): FEB. 4 1921
8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): 4600 SHAMROCK AVE.
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: ----

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: -----
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4600 SHAMROCK AVE.
10f. ZIP CODE: 21206
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ELEMENTARY; College (1-4 or 5+): ---
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER
16b. KIND OF BUSINESS/INDUSTRY: OWN HOME
17. FATHER'S NAME (First, Middle, Last): Nicholas Beiser
18. MOTHER'S NAME (First, Middle, Maiden Surname): Eva Nies
19a. INFORMANT'S NAME (Type/Print): RALPH PARKS, SR.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4600 SHAMROCK AVE., BALTIMORE MD. 21206
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cem
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John F. Schimunek
22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Baltimore Md. 21213

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Brian H. Kahn, MD
29c. LICENSE NUMBER: D28662
29d. DATE SIGNED (Month, Day, Year): ▶ 4/17/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. KAHN 5820 YORK RD.
31. DATE FILED (Month, Day, Year): APR 20 1989
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

Item18,19a 12-6-89 FilmG658 W.H. Per F/H
19b

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11283

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Raymond | | Payton | 4 30 89 | 9:45 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-28-6812 | 1 [#] M 2 ☐ F | 55 YRS. | | | 1/13/34 | Md. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 527 N. Pulaski Street | Baltimore | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md. | | Baltimore | 1 [#] YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 527 N. Pulaski St. | 21223 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 [#] Divorced | 1 ☐ YES 2 [#] NO | 1 ☐ YES 2 ☐ NO Specify: | Specify: Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | | | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Isaiah ~~Payton~~ Payton | Lillian M. ~~Payson~~ Payton |

| 19a. INFORMANT'S NAME | 19b. ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Raymond ~~Payson~~ Payton Jr. | ~~1665~~ 1565 Richland St. Baltimore, Md. 21217 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [#] Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Mt. Auburn | |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Cecil A Estep | Estep Brothers Funeral Home P.A. 1300 Eutaw Place |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hypertensive arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 [X] NO | 1 ☐ YES 2 ☐ NO |
| INSPECTION | |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 [X] Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Ann Dixon | OCME | ▶ 4/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Ann M. Dixon, M.D., Deputy Chief 111 Penn St. Balto.MD.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 2 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89-11284

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) FLORENCE GERTRUDE PETTIT / FLORENCE PETTIT | | 2. DATE OF DEATH MONTH 04 DAY 03 YEAR 89 | [redacted] 1:25 AM |
| 4. SOCIAL SECURITY NUMBER 218-40-1201 / 218-40-1201 | 5. SEX 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday) 99 99 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN. |
| 7. DATE OF BIRTH (Month, Day, Year) 8-27-89 / 8/27/1889 | 8. BIRTHPLACE (State or Foreign Country) MARYLAND Baltimore | | |
| 9a. FACILITY NAME (If not institution, give street and number) SINAI Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore Baltimore Md | 9c. COUNTY OF DEATH 1 N/A | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE MARYLAND Md | 10b. COUNTY BALTIMORE Baltimore City | 10c. CITY, TOWN OR LOCATION BALTIMORE Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☒ NO |
| 10e. STREET AND NUMBER 714 Walker Ave. | 10f. ZIP CODE 21212 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | 16b. KIND OF BUSINESS/INDUSTRY N/A | |
| 17. FATHER'S NAME (First, Middle, Last) Walter XXXXXXXXX Murray Sevier | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rebecca Marshall | | |
| 19a. INFORMANT'S NAME (Type/Print) Burnett A. Pettit | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 714 Walker Ave. Balto. Md. 21212 | | |
| 20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery | 20c. LOCATION — City or Town, State Balto. City | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Dennis Sleaford Kerbis | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road 21212 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. SEPSIS
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. INFECTION FOCUS UNKNOWN.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER MOHAMAD ATTAR, MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 04 03 89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MOHAMAD ATTAR 6931 DONACHIE Rd, Apt G BALTO, MD 21239

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year) APR 7 1989 | 32. REGISTRAR'S SIGNATURE |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89-11285

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARY MARGARET PRAGLOWSKI | | | 2. DATE OF DEATH: MONTH 4 DAY 11 YEAR 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 215 63 1263 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 76 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10 16 1912 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 1712 Dundalk Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1712 Dundalk Avenue | | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 8+): Strayer Bus. | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Thomas Doyle | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary McNamara | |
| 19a. INFORMANT'S NAME (Type/Print): Dwight & Darlene VanKeuren | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1911 Holborn Road - Baltimore, Md. 21222 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): 4/14/89 Holy Rosary Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Walter J. Dabrowski | 22. NAME AND ADDRESS OF FACILITY: Walter Dabrowski Funeral Chapel 1005 Dundalk Avenue - 21224 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Probable acute myocardial infarction

DUE TO (OR AS A CONSEQUENCE OF):
b. Diabetes mellitus

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. Chronic renal failure

DUE TO (OR AS A CONSEQUENCE OF):
d. ASHD

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Rehme Boland | 29c. LICENSE NUMBER: D14826 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/12/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 13 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Pragloski |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11286
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 2 must be mailed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, [illegible] be attached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MAGGIE M. PARKER | | 2. DATE OF DEATH: MONTH APRIL DAY 02, YEAR 1989 | 3. TIME OF DEATH: 12:15A M |
| 4. SOCIAL SECURITY NUMBER: 218-03-6873 D | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 91 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year): 2-14-08 |
| 8. BIRTHPLACE (State or Foreign Country): Md. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: USA | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1130 Wilmot Ct | 10f. ZIP CODE: 21202 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ? College (1-4 or 5+): ? | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Alfred Chambers | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Jane Chambers |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Viola Pinder | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1130 Wilmot Ct 21202 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Western Star Cem. | 20c. LOCATION — City or Town, State: Catonsville, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [illegible] Powell FS | 22. NAME AND ADDRESS OF FACILITY: 1206 W North Ave 21217 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | GASTROINTESTINAL BLEED | 24 hours |
| DUE TO (OR AS A CONSEQUENCE OF): b. | SEPSIS | 2-3 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] | 29c. LICENSE NUMBER: D36943 | 29d. DATE SIGNED (Month, Day, Year): 4/2/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 5 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall |

DHMH-15 Rev 1/89

89 11286

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-11287

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WILLIAM M. PATE | | | 2. DATE OF DEATH (Month, Day, Year): April 1, 1989 | 3. TIME OF DEATH: 1287 M |
| 4. SOCIAL SECURITY NUMBER: 246-12-0015 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10-23-1921 | 8. BIRTHPLACE (State or Foreign Country): N. C. |
| 9a. FACILITY NAME (If not institution, give street and number): 3222 Orlando Ave. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3222 Orlando Ave. | | 10f. ZIP CODE: 21234 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WWII & Korea | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Yrs. / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Foreman | 16b. KIND OF BUSINESS/INDUSTRY: Beth. Steel Shipyard | |
| 17. FATHER'S NAME (First, Middle, Last): William M. Pate | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucille Barbour | |
| 19a. INFORMANT'S NAME (Type/Print): Katherine M. Pate | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3222 Orlando Ave.,Balto., Md. 21234 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery 4-5-89 | 20c. LOCATION — City or Town, State: Balto., Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Roy H. Cather / Roy H. Cather | | 22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck, Inc. 5305 Harford RD Baltimore, MD 21214 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Metastatic lung cancer | 9 MONTHS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic Prostate cancer

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M. Purtell Staff Physician | 29c. LICENSE NUMBER: D17714 | 29d. DATE SIGNED (Month, Day, Year): 4/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael Purtell, M.D. Francis Scott Key Medical Center Room 104

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 4 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89-11288

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Chandubhai B. Patel
PATEL CHANDUBHAI B

2. DATE OF DEATH (Month, Day, Year): 04/04/89

3. TIME OF DEATH: 0855 M

4. SOCIAL SECURITY NUMBER: 127-48-6252

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 58 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.

7. DATE OF BIRTH (Month, Day, Year): 10-29-30

8. BIRTHPLACE (State or Foreign Country): India

9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City

9c. COUNTY OF DEATH: --------

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Woodlawn

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 7216 Kennebunk Road

10f. ZIP CODE: 21207

10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: Asian Indian

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): | College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineer

16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): Bhailalbhia Patel

18. MOTHER'S NAME (First, Middle, Maiden Surname): Kashiba

19a. INFORMANT'S NAME (Type/Print): Shantaben Patel

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Security Process, Inc.

20c. LOCATION — City or Town, State: Baltimore, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ S. M. Loewner

22. NAME AND ADDRESS OF FACILITY: MacNabb Funeral Home
Catonsville, MD 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ACUTE MYOCARDIAL INFARCT — 24hrs
DUE TO (OR AS A CONSEQUENCE OF):
b. CORONARY ATHEROSCLEROSIS — YEARS
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS
HYPERTENSION

24a. WAS AN AUTOPSY PERFORMED? 1 [✓] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [✓] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Bert F. Morton, M.D.

29c. LICENSE NUMBER: D08949

29d. DATE SIGNED (Month, Day, Year): ▶ 4/4/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BERT F. MORTON, M.D. ST. AGNES HOSPITAL

31. DATE FILED (Month, Day, Year): APR 6 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11289
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RONALD LILLARD PATRICK (RONALD PATRICK)
2. DATE OF DEATH (Month, Day, Year): 04 09 89
3. TIME OF DEATH: 1400 PM
4. SOCIAL SECURITY NUMBER: 217-34-3249
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 50 XXXX YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8-20-38
8. BIRTHPLACE (State or Foreign Country): Tennesse
9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hospital (BALTO. CO. GEN HOSP)
9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown (RANDALLSTOWN)
9c. COUNTY OF DEATH: Baltimore (BALTO.)

RESIDENCE OF DECEDENT

10a. STATE: Maryland (MD)
10b. COUNTY: Baltimore (BALTO)
10c. CITY, TOWN OR LOCATION: XXXXXXXXXXXX Baltimore
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 224 Hopkins Road (224 HOPKINS RD. BALTO. MD)
10f. ZIP CODE: 21212 (21212)
10g. CITIZEN OF WHAT COUNTRY? U.S.A. (U.S)
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XX YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Salesman
16b. KIND OF BUSINESS/INDUSTRY: Roofing
17. FATHER'S NAME (First, Middle, Last): Lillard Glenn Patrick
18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy Pearl Bowman
19a. INFORMANT'S NAME (Type/Print): Lucie Cassedy Patrick
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 224 Hopkins Road Baltimore, Maryland 21212
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lakeview Cemetery
20c. LOCATION — City or Town, State: Sykesville Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis J. Kienapfel — X ▶ Mitchell-Wiedefeld Inc
22. NAME AND ADDRESS OF FACILITY: 6500 York Rd Balto Md 21212 (6500 York Rd Balto. MD 21212)

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | acute Myocardial Infarction | 30 MIN |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF): | ASCVD | unknown |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: 0 Autopsy

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Stanley Z. Felsenberg M.D. Deputy Medical Examiner
29c. LICENSE NUMBER: D01085
29d. DATE SIGNED (Month, Day, Year) ▶ April 9 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STANLEY Z. FELSENBERG M.D. 11 E. Chase St 21202
31. DATE FILED (Month, Day, Year): APR 11 1989
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11290
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Eric F. Perry SR. | | | 2. DATE OF DEATH: MONTH 4 DAY 1 YEAR 89 | 3. TIME OF DEATH: 6:40 P M |
| 4. SOCIAL SECURITY NUMBER: 212-94-6179 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 23 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 1/5/66 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Johns Hopkins Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1738 HOMESTEAD STREET | | 10f. ZIP CODE: 21218 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES XXX | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: XXX | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SECURITY GUARD | | 16b. KIND OF BUSINESS/INDUSTRY: FULLTIME |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM PERRY SR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): JESSIE BISHOP | | |
| 19a. INFORMANT'S NAME (Type/Print): JESSIE L. PERRY | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1738 HOMESTEAD STREET BALTIMORE, MD 21218 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE CEMETERY | | 20c. LOCATION — City or Town, State: BALTIMORE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin L. Williams | | 22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple (6) Gunshot Wounds to Chest and Extremities | |
| DUE TO (OR AS A CONSEQUENCE OF): | (unspecified) | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): | b. | |
| DUE TO (OR AS A CONSEQUENCE OF): | c. | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [XX] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 4-1-89 | 6:00P M | 1 [ ] YES 2 [X] NO | subject was shot |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| house | 1436 Carswell St., Baltimore, Md. |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| John C. Goodin MD | OCME | 4-2-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn St., Balto., Md. 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 5 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 11290

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11291

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, if attached, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MERCEDES BORDAS ROCK | 2. DATE OF DEATH (Month, Day, Year): APRIL 6, 1989 | 3. TIME OF DEATH: 10:19P M | |
| 4. SOCIAL SECURITY NUMBER: 578-07-9602 | 5. SEX: 1 ☐ M 2 ☒ F | 5. AGE (In yrs. last birthday): 77 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7. DATE OF BIRTH (Month, Day, Year): 6/28/11 | 8. BIRTHPLACE (State or Foreign Country): New York | | |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE City | 9c. COUNTY OF DEATH: N/A | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: N/A | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2901 Fendall Road | 10f. ZIP CODE: 21207 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 Years | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary | 16b. KIND OF BUSINESS/INDUSTRY: Goodman, Gable & Gould |
| 17. FATHER'S NAME (First, Middle, Last): Peter Bordas | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Angela Bordas | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Karen David | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3255 Forest Hills Drive Redding, CA 96002 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Carroll Cremation Services | 20c. LOCATION — City or Town, State: Hampstead, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD. 21133 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | cardiogenic shock | 6 hours |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | ventricular septal defect | 6 hours |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | anterior myocardial infarction | 24 hours |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | coronary artery disease | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D29423 | 29d. DATE SIGNED (Month, Day, Year): April 7, 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHNS HOPKINS HOSPITAL | | |
| 31. DATE FILED (Month, Day, Year): APR 10 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 1291

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11292
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be removed by the funeral director and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~[illegible]~~ BYARDES ROBINSON
2. DATE OF DEATH: MONTH 05 DAY 04 YEAR 89
3. TIME OF DEATH: 2:30 A M
4. SOCIAL SECURITY NUMBER: 237324817
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 62 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 07/13/26
8. BIRTHPLACE (State or Foreign Country): NORTH CAROLINA
9a. FACILITY NAME (If not institution, give street and number): Loch Raven VA Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1803 Ashburton St. Baltimore, MD
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY? US
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ROOFER
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): JOHN Robinson
18. MOTHER'S NAME (First, Middle, Maiden Surname): ELLA
19a. INFORMANT'S NAME (Type/Print): ARLETHEA Robinson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5216 Wilton
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VET. CEM
20c. LOCATION — City or Town, State: OWINGS MILLS, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dorothy Hecht #281
22. NAME AND ADDRESS OF FACILITY: E.L. PHILLIPS 1721-27 N. MONROE STREET 21217

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Probable Sepsis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Probable GI Bleed - gastrointestinal bleed

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Maria M. Garcia, MD house staff physician
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 05/04/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Maria M. Garcia - Loch Raven VA Hospital
31. DATE FILED (Month, Day, Year): MAY 8 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

3

OHMH-16 Rev 1/89

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89 11293

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LEOLA RICHARDSON
2. DATE OF DEATH: MONTH 05 DAY 2 YEAR 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 74 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 03 11 15
8. BIRTHPLACE (State or Foreign Country): SOUTH CAROLINA
9a. FACILITY NAME (If not institution, give street and number): MERCY MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1535 N. CAROLINE STREET
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY: US
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): BOSTON ROWE
18. MOTHER'S NAME (First, Middle, Maiden Surname): LILUS DAILEY
19a. INFORMANT'S NAME (Type/Print): LILLIE MAE SPEARS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1535 North Caroline Street Baltimore MD 21213
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. ZOIN CEMETERY
20c. LOCATION — City or Town, State: BALTIMORE MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Loretta Toth #281
22. NAME AND ADDRESS OF FACILITY: E.L. PHILLIPS 1721 MONROE ST. 21217

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Arteriosclerotic Cardio Vascular Disease | year |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Decubitus Ulcer, severe | Months |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Urinary Tract Infection, Recent | 1 Months |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Senile dyspnea, Old Cerebrovascular Accident

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Rolando V. Floro MD
29c. LICENSE NUMBER: D01860
29d. DATE SIGNED (Month, Day, Year): 5-4-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 707 E. Fort Ave, Balt. MD 21230
31. DATE FILED (Month, Day, Year): MAY 8 1989
32. REGISTRAR'S SIGNATURE: Gubi Davidson-Ramsey

OHMH-15 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MD 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 may be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

3

68 11583

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11294
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. The burial-transit permit. Pages 1, 2, 3 should
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Bessie V. Roberts
2. DATE OF DEATH (Month, Day, Year): 5 2 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 216-12-9891
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 65 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6 22 1923
8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): 3805 Chatham Road
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3805 Chatham Road
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? U S A
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Delancey Bryant
18. MOTHER'S NAME (First, Middle, Maiden Surname): Regina Hill
19a. INFORMANT'S NAME (Type/Print): Charles A. Roberts, Jr
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3805 Chatham Road Baltimore, Md 21215
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park
20c. LOCATION — City or Town, State: Arbutus, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Portia L. Ebron
22. NAME AND ADDRESS OF FACILITY: March F/H West, 4300 Wabash Avenue

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Coronary Artery Disease. — DUE TO (OR AS A CONSEQUENCE OF): — Appr 19 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Chronic Obstructive Lung disease Dx 5/2/89 — DUE TO (OR AS A CONSEQUENCE OF):
c. Arthritis — DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: D 15533
29d. DATE SIGNED (Month, Day, Year): ▶ 5/4/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHRYSOLOGUE GAKUBA
31. DATE FILED (Month, Day, Year): MAY 5 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 11294

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11295
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ZACK ROGERS SR. | | | | 2. DATE OF DEATH (Month, Day, Year): 4 27 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 216-09-1703 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | | 7. DATE OF BIRTH (Month, Day, Year): 6-7-02 | 8. BIRTHPLACE (State or Foreign Country): S.C. |
| 9a. FACILITY NAME (If not institution, give street and number): 2420 LAURETTA AVENUE | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MD | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO | |
| 10e. STREET AND NUMBER: 2420 LAURETTA AVENUE | | 10f. ZIP CODE: 21223 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TRUCKDRIVER | | 16b. KIND OF BUSINESS/INDUSTRY: RETIRED | |
| 17. FATHER'S NAME (First, Middle, Last): JOHN C. ROGERS | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): SABRA POOLE | | | |
| 19a. INFORMANT'S NAME (Type/Print): EARL RICE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2458 NEVADA STREET/BALTIMORE, MD. 21216 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOUNT AUBURN CEMETERY | | 20c. LOCATION — City or Town, State: BALTIMORE CITY, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vanessa Davis | | 22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Ventricular Arrhythmia
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Arteriosclerotic Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic obstructive Pulmonary Disease, severe

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Boarding Home | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Darrell M. Gray M.D. | 29c. LICENSE NUMBER: D21711 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/28/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Darrell M. Gray, M.D. 2329 Arunah Ave. Baltimore, Md. 21216 | | |
| 31. DATE FILED (Month, Day, Year): MAY 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 1295

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11296
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BATES Robert | | 2. DATE OF DEATH (Month, Day, Year): 4 26 89 | 3. TIME OF DEATH: 6 30 A M |
| 4. SOCIAL SECURITY NUMBER: 220-07 4676 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 89 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10/14/00 |
| 8. BIRTHPLACE (State or Foreign Country): S. Carolina | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Ashburton | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3520 N. Hilton Rd. | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER-Retired | 16b. KIND OF BUSINESS/INDUSTRY: SPARROWS Pt. Md. |
| 17. FATHER'S NAME (First, Middle, Last): Landy BATES | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): SYLVIA TERRANCE | |
| 19a. INFORMANT'S NAME (Type/Print): Lillian Bates Payton | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 911 Lyndhurst Balto. Md 21229 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE Cemetery | 20c. LOCATION — City or Town, State: BALTIMORE MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gloria Adams Jones | | 22. NAME AND ADDRESS OF FACILITY: MARSHALL W. JONES, JR. F.H. P.A. 401 Edmondson Ave. 21229 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | ASCVD & CARDIAC PACEMAKER | years |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Chronic heart FAILURE | yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | peripheral Vascular disease | years |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dementia secondary to alcoholism

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D.069 44 | 29d. DATE SIGNED (Month, Day, Year): 4/27/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. A. HYACHT MD 101 WEST READ ST 21201 | | |
| 31. DATE FILED (Month, Day, Year): MAY 1 - 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-18 Rev 1/89

89 1296

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11297
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages ___ be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): FRANKLIN FRANCIS RUSSO, SR. | | | 2. DATE OF DEATH: MONTH 4 DAY 29 YEAR 89 | 3. TIME OF DEATH: 4:15P.M. M |
| 4. SOCIAL SECURITY NUMBER: 212-09-0021 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3/4/ 1911 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 236 S. Loudon Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore city | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 236 S Loudon Avenue | | 10f. ZIP CODE: 21229 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mailer | 16b. KIND OF BUSINESS/INDUSTRY: News American | |
| 17. FATHER'S NAME (First, Middle, Last): Peter Russo | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Loric | |
| 19a. INFORMANT'S NAME (Type/Print): Lula J. Russo | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 236 S. Loudon Avenue Baltimore, Maryland 21229 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park | 20c. LOCATION — City or Town, State: Elkridge, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Maryland 21229 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic non-small cancer of lung | 15 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: D18587 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul Gormley St. Agnes Hospital Oncology Dept.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |

OHMH-16 Rev 1/89

89 1297

89 11298

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): PATRICIA ROSEMOND
2. DATE OF DEATH (Month, Day, Year): 4 - 26 - 89
3. TIME OF DEATH: 1120p M
4. SOCIAL SECURITY NUMBER: 214-52-3710
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 38 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8/12/50
8. BIRTHPLACE (State or Foreign Country): Florida

9a. FACILITY NAME (If not institution, give street and number): Liberty Medical
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: None

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: none
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2317 Lauretta Avenue
10f. ZIP CODE: 21223
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 11th--GED — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nurses Assist.
16b. KIND OF BUSINESS/INDUSTRY: Health

17. FATHER'S NAME (First, Middle, Last): Miles Patterson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Rosemond

19a. INFORMANT'S NAME (Type/Print): Catherine Daniels
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2317 Lauretta Ave- Balto., Md. 21223

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cem.
20c. LOCATION — City or Town, State: Balto., Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Juanita D. Morton
22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons, 1701 Laurens St, Balto., Md. 21217

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hepatic Encephalopathy | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): Sepsis | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
28. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 4/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. ANNETTE [illegible], Liberty Medical Center

31. DATE FILED (Month, Day, Year): MAY 18 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11299
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARGARET E. RABENAU / MARGARET E. RABENAU | | 2. DATE OF DEATH (Month, Day, Year): APRIL 25 1989 | 3. TIME OF DEATH: 945 PM |
| 4. SOCIAL SECURITY NUMBER: 219-30-5117 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 54 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): NOV. 11 1934 |
| 8. BIRTHPLACE (State or Foreign Country): MD. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): LORD F. MASON NURSING HOME | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH: ---- | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: MD. | 10b. COUNTY: ---- | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 5906 GLEN FALLS AVE. | 10f. ZIP CODE: 21206 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5+): n/a | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CONSUMER LOAN/TELLER | 16b. KIND OF BUSINESS/INDUSTRY: BANKING | |
| 17. FATHER'S NAME (First, Middle, Last): GEORGE FREDERICK | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH JOHANNA | | |
| 19a. INFORMANT'S NAME (Type/Print): MICHAEL D. RABENAU (SON) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5906 GLEN FALLS AVE., BALTO. MD. 21206 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOST HOLY REDEEMER CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Eugene J Lastnik | 22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Balto. Md. 21213 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arrhythmia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Renal failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Diabetes | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Atherosclerotic cardiovasc disease HTN

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: finucane

29c. LICENSE NUMBER: D24334

29d. DATE SIGNED (Month, Day, Year): 4/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FINUCANE FSK

31. DATE FILED (Month, Day, Year): MAY 1 1989

32. REGISTRAR'S SIGNATURE: Juliet Davidson-Kendall

DHMH-16 Rev 1/89

89 11299

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11300
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Samuel Thomas Rotondo | | | 2. DATE OF DEATH (Month, Day, Year): April 27, 1989 | 3. TIME OF DEATH: 7:25A M |
| 4. SOCIAL SECURITY NUMBER: 215-12-1941 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 69 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): Oct. 17, 1919 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: ------- | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: --------- | 10c. CITY, TOWN OR LOCATION: Balto.City,Md. | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1506 Belt St. | 10f. ZIP CODE: 21230 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 5+): ----- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Estimater Planner | 16b. KIND OF BUSINESS/INDUSTRY: Coast Guard | |
| 17. FATHER'S NAME (First, Middle, Last): Thomas ------ Rotondo | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances ----- Civello | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs.Lillian M.Rotondo | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1506 Belt St.Balto.Md. 21230 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: A.A.Co.Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Daniel A. Naylor | 22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home,130 E.Fort Ave Balto.Md.21230 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. End stage Renal disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Nephrosclerosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dep ression

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: James J. Cole, M.D. | 29c. LICENSE NUMBER: n/a | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/27/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James J. Cole, M.D. c/o Maryland General Hospital | | |
| 31. DATE FILED (Month, Day, Year): MAY 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

88 11300

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11301

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WALTER. RINEHART | | | 2. DATE OF DEATH (Month, Day, Year): 04 25 89 | 3. TIME OF DEATH: 12.45 P M |
| 4. SOCIAL SECURITY NUMBER: 216104080 | 5. SEX: 1 M 2 F | 6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12-10-06 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Balto. City |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore City | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| 10e. STREET AND NUMBER: 4023 Orchard Avenue | 10f. ZIP CODE: 21225 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 Never Married 2 Married 3 Widowed 4 X Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 years | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self Employed | 16b. KIND OF BUSINESS/INDUSTRY: Produce |
| 17. FATHER'S NAME (First, Middle, Last): Harry Rinehart | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Blanche Snyder | |
| 19a. INFORMANT'S NAME (Type/Print): Ronald Rinehart | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4023 Orchard Avenue Baltimore, Maryland 21225 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Bendersville Lutheran Cemetery | 20c. LOCATION — City or Town, State: Bendersville, Pa. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard E Jones | | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Resp. failure

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. COPD CA of lung

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

① Metabolic Acidosis
② progressive Renal failure

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPITAL | | |
| 27. MANNER OF DEATH: 1 Natural 2 Accident 3 Suicide 4 Homicide 8 Pending investigation 8 Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURED<br>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Sita Yanamadala | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 4/25/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SITA YANAMADALA

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 1 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Forrester |

DHMH-16 Rev 1/89

89 11302

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DAVID RAY JR. David Ray Jr.
2. DATE OF DEATH (Month, Day, Year): 4 7 89
3. TIME OF DEATH: 2:45 AM
4. SOCIAL SECURITY NUMBER: 249-44-4612
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 59 59 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3/15/1930
8. BIRTHPLACE (State or Foreign Country): South Carolina
8a. FACILITY NAME (If not institution, give street and number): Key Circle Hospice
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md.
9c. COUNTY OF DEATH: —

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince Georges
10c. CITY, TOWN OR LOCATION: Hyattsville
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 5516 56th Street
10f. ZIP CODE: 20747
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cement Finisher
16b. KIND OF BUSINESS/INDUSTRY: Construction
17. FATHER'S NAME (First, Middle, Last): David Ray Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Ray
19a. INFORMANT'S NAME (Type/Print): Betty M. Ray Wife
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1214 Washington St. Greenville, South Carolina
Pt. medical Record.
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rest Heaven Cemetery
20c. LOCATION — City or Town, State: Greenville, S.C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert M. Estep
22. NAME AND ADDRESS OF FACILITY: 1300 Eutaw Place, Balto, Md — Estep Brother Funeral Service, P.A.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardio Pul arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | SP CVA & Seizure disorder, Anotic encephalopathy. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dx of bronchopneumonia & Atelectasis c/s c/89.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gulab M Shah MD
29c. LICENSE NUMBER: D26750
29d. DATE SIGNED (Month, Day, Year): 4/7/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): APR 20 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 11303

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Billie Reamer — WILLODENE (BILLIE) REAMER | 2. DATE OF DEATH (Month, Day, Year): 4 / 14 / 89 | 3. TIME OF DEATH: 555 P M | |
| 4. SOCIAL SECURITY NUMBER: 419-36-7503 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 56 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10/15/32 — 8. BIRTHPLACE (State or Foreign Country): ALABAMA |
| 9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: [illegible] | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 6507 TROTWOOD CT. | 10f. ZIP CODE: 21209 | 10g. CITIZEN OF WHAT COUNTRY?: usa | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES XX | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: AT HOME | |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM LITTLE | 18. MOTHER'S NAME (First, Middle, Maiden Surname): REBA LANSFORD | | |
| 19a. INFORMANT'S NAME (Type/Print): MR. JERRY REAMER | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6507 TROTWOOD CT. BALTO., MD 21209 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OHEB SHALOM MEMORIAL PARK | 20c. LOCATION — City or Town, State: REISTERSTOWN, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jack H Levinson | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Arrest / B — DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Severe COPD — DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. SEPSIS — DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Loc Le MD House Officer | 29c. LICENSE NUMBER: N/A | 29d. DATE SIGNED (Month, Day, Year): 4/14/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Ramsey |

DHMH-16 Rev 1/89

89 1303

Candace Arndt
Sears COPD
SEPSIS

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11304
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROLAND F. RECKER, SR.

2. DATE OF DEATH (Month, Day, Year): 4 13 89

3. TIME OF DEATH: 9 50 PM

4. SOCIAL SECURITY NUMBER: 214-14-4969

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 68 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 7/17/20

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Anne Arundel

10c. CITY, TOWN OR LOCATION: Linthicum

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 380 Centerhill Avenue

10f. ZIP CODE: 21090

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: WW II

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+): 2yrs.

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales Manager

16b. KIND OF BUSINESS/INDUSTRY: Revere Copper & Brass, Inc.

17. FATHER'S NAME (First, Middle, Last): Joseph Recker

18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Bell

19a. INFORMANT'S NAME (Type/Print): Hilda Recker

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 380 Centerhill Ave. Linthicum, Maryland 21090

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery

20c. LOCATION — City or Town, State: Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]

22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc.
4107 Wilkens Avenue Baltimore, Md. 21229

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary Embolism

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- Arteriosclerotic Cardiovascular Disease
- Cholecystitis

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 6 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 6 [X] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.

29c. LICENSE NUMBER: D26652

29d. DATE SIGNED (Month, Day, Year): 4/13/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JORGE CALDERON M.D.

31. DATE FILED (Month, Day, Year): APR 20 1989

32. REGISTRAR'S SIGNATURE: [signature]

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

89 1130R

89 11305

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Elease M. Redmon (DORSEY) | | | 2. DATE OF DEATH (Month, Day, Year): 4 / 19 / 89 | 3. TIME OF DEATH: 5:45 P.M. M |
| 4. SOCIAL SECURITY NUMBER: 220-44-2370 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 35 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12/27/53 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Med. Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Balt. Md. 21224 | | 9c. COUNTY OF DEATH: Balt. City. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 960 ASHBRIDGE DRIVE APT D | | 10f. ZIP CODE: 21221 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNKNOWN | 16b. KIND OF BUSINESS/INDUSTRY: NA | |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM WRIGHT | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ALICE M. DORSEY | |
| 19a. INFORMANT'S NAME (Type/Print): ALICE DORSEY | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 960 ASHBRIDGE DRIVE APT. D/BALTIMORE, MD 21221 | | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): EASTVIEW MEMORIAL PARK CEMETERY | 20c. LOCATION — City or Town, State: DUNDALK, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Francis X Green | 22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiorespiratory arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. End stage Multiple Myeloma. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 5 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Larry Waterberg, M.D | D0 9559 | ▶ 4/20/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LARRY WATERBURY M.D., FSKMC, 4940 Eastern, Balt. Md. 21224

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 24 1989 | Julia Davidson-Lindsay |

DHMH-15 Rev 1/89

89 11306

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Franklin D. Rich
2. DATE OF DEATH — MONTH: 4 DAY: 14 YEAR: 1989
3. TIME OF DEATH: 105 AM
4. SOCIAL SECURITY NUMBER: 229-56-6329
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 45 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10/25/43
8. BIRTHPLACE (State or Foreign Country): Va
9a. FACILITY NAME (If not institution, give street and number): Sinai Hosp of Baltimore
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3625 Reisterstown Road
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Brick Layer
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Robert J. Rich
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mazie Sutton
19a. INFORMANT'S NAME (Type/Print): Lucille A. Rich
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3625 Reisterstown Road Balto, Md 21215
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery
20c. LOCATION — City or Town, State: Baltimore, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Willie Edmonds
22. NAME AND ADDRESS OF FACILITY: March F H. West 4300 Wabash Ave

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused tha death. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, ahock, or heart feilure. List only one cause on eech line.

Approximeta Interval Between Onset and Daath

IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a. Pancreatic CA

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in tha underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Stephen O'Neil MD
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year) ▶ 4/14/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stephen O'Neil Sinai Hosp. of Baltimore

31. DATE FILED (Month, Day, Year): APR 18 1989 Julia
32. REGISTRAR'S SIGNATURE: Benson-Randall

DHMH-18 Rev 1/89

88 11306

89 11307

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | (RICHARDS) | 2. DATE OF DEATH Month / Day / Year | | 3. TIME OF DEATH |
| Anthony | | | Richardson | 4-16-89 | | 3:34PM M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTHPLACE (State or Foreign Country) |
| 214-86-6977 | 1 [X] M 2 [ ] F | 24 YRS. | | 10-30-64 | | MD. |

| | | | |
|---|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH | |
| University Hospital | Baltimore City | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
| MD. | | BALTIMORE | 1 [X] YES 2 [ ] NO |

| | | |
|---|---|---|
| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
| 2861 N. EDGECOMBE CIR. APT 3-E | 21215 | USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 1 [ ] YES 2 [X] NO Specify: | Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| UNKNOWN | | UNEMP. | NA |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
| WILLIAM D. RICHARDS | JEANETTE SCOTT |

| | |
|---|---|
| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| JEANETTE SCOTT | 2861 N. EDGECOMBE CIR. APT 3-E BALTO. MD. 21215 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | KING MEM. PARK | RANDALLSTOWN, MD. |

| | |
|---|---|
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
| ▶ Ernest Davis | WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple gunshot wounds | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 4-12-89 | 2:52PM | 1 [ ] YES 2 [X] NO | Subject shot |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| | street | | | 900 block Cloney Street |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
| | OCME | ▶ 4-17-89 |

| | |
|---|---|
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | |
| James Kaplan, M.D. | 111 Penn Street, Baltimore, MD 21201 VC |

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
| APR 20 1989 | Julia Davidson-Landers |

DHMH-16 Rev 1/89

NCCU7

S 237 82 20 1
RITTER, FRANCES M
06/23/38 F

89 11308

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| FRANCES | MARIE | RITTER | APRIL 18, 1989 | 1:50 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-34-2930 | 1 ☐ M 2 ☒ F | 50 YRS. | | | JUNE 23, 1938 | WEST VIRGINIA |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| THE JOHNS HOPKINS HOSPITAL | BALTIMORE CITY | BALTIMORE |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| DELAWARE | SUSSEX | LEWES | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| RD 4 BOX 334 | 19958 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 8 | - - - - - | DOMESTIC WORKER | PRIVATE |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| DELBERT BREWER | MADELINE POND |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| CHARLES ROSS RITTER | RD.4 BOX 334 LEWES, DELAWARE 19958 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | WHITE CHAPEL CEMETERY | MILTON, SUSSEX, DELAWARE |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ M. Andrew Duvall | FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD. WEST SILVER SPRING, MD |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. acute hydrocephalus | 4/17 |
| DUE TO (OR AS A CONSEQUENCE OF): | b. subarachnoid hemorrhage | 4/13. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☑ NO | HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☒ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)

1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Deborah J. Arndell MD | | ▶ 04/18/89. |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Deborah J. Arndell MD. 600 W. Lake Street. Balt MD. 21205

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 25 1989 | Gordon Landers |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

88 11308

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11309
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): JOHN N. RHODES, JR

**2. DATE OF DEATH** MONTH: 4 DAY: 12 YEAR: 89

**3. TIME OF DEATH**: 8 47 AM M

**4. SOCIAL SECURITY NUMBER**: 216-32-3736

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 53 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 8-23-35

**8. BIRTHPLACE** (State or Foreign Country): Md

**9a. FACILITY NAME** (If not institution, give street and number): Homewood Hospital

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTIMORE

**9c. COUNTY OF DEATH**: BALTIMORE

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 [X] YES 2 [ ] NO

**10e. STREET AND NUMBER**: 401 N Loudon Ave

**10f. ZIP CODE**: 21229

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS** 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: Black

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.)

**16b. KIND OF BUSINESS/INDUSTRY**

**17. FATHER'S NAME** (First, Middle, Last): John N. Rhodes, SR

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Margaret Shaw

**19a. INFORMANT'S NAME** (Type/Print): Annie M. Rhodes

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 401 N. Loudon Ave Baltimore, Md 21229

**20a. METHOD OF DISPOSITION** 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Garrison Forest Vet

**20c. LOCATION — City or Town, State**: Owings Mills, Md

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Dale March

**22. NAME AND ADDRESS OF FACILITY**: March F/H 4300 Wabush ave

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. _____ DUE TO (OR AS A CONSEQUENCE OF):

c. _____ DUE TO (OR AS A CONSEQUENCE OF):

d. _____

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

New onset Atrial Fibrilation
HYPERTENSION, ALCOHOL ABUSE

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [ ] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [X] YES 2 [X] NO

**26. PLACE OF DEATH** (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH** 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year) — **28b. TIME OF INJURY** — M — **28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO — **28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify) — **28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Dobbin Chow MD

**29c. LICENSE NUMBER**: D34851

**29d. DATE SIGNED** (Month, Day, Year): April 12, 1989

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): 3100 Wyman Park Drive, Baltimore MD 21211

**31. DATE FILED** (Month, Day, Year): APR 18 1989

**32. REGISTRAR'S SIGNATURE**: Julia Henderson-Randall

DHMH-16 Rev 1/89

89 11310

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Dorothy W Rochelle | | 2. DATE OF DEATH (Month, Day, Year): APRIL 9 1989 | 3. TIME OF DEATH: 9:42 A M |
| 4. SOCIAL SECURITY NUMBER: 214 14 9152 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 79 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7. DATE OF BIRTH (Month, Day, Year): AUG 28, 1909 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND | | |
| 9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE MD | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2525 W Belvedere | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY? US U. S. of A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X | 14. RACE — American Indian, Black, White, etc. Specify: XXXXXX BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOMESTIC | 16b. KIND OF BUSINESS/INDUSTRY: PRIVATE FAMILY | |
| 17. FATHER'S NAME (First, Middle, Last): THOMAS D. WALKER | 18. MOTHER'S NAME (First, Middle, Maiden Surname): BERTHA SHARPS | | |
| 19a. INFORMANT'S NAME (Type/Print): REV. DANIEL W. WALKER | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4800 FORGE ROAD PERRY HALL, MARYLAND 21128 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): 4/13/89 COMMUNITY BAPT. CHURCH CEM. | 20c. LOCATION — City or Town, State: JOPPA (BALTO.Co) Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lewis T. Gwynn | 22. NAME AND ADDRESS OF FACILITY: LEWIS T. GWYNN FUNERAL HOME 21215 - 6393 4517 PARK HEIGHTS AVENUE BALTIMORE, MARYLAND | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pulmonary Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Sepsis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. COPD | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal Failure, COPD, DM

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | | | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| MD | | ▶ 4/9/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PATRICIA GAIL ROBERTS MD - Resident

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 11 1989 | Julia Davidson-Randall |

DHMH-15 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11311

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

N

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): TILLIE (PELAGIA) A. ROMECKI
2. DATE OF DEATH: MONTH 4 DAY 16 YEAR 89
3. TIME OF DEATH: 0608 HRS M
4. SOCIAL SECURITY NUMBER: 219-26-1902
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 87 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2-12-1902
8. BIRTHPLACE (State or Foreign Country): POLAND
9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTO. CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: BALTIMORE CITY
10c. CITY, TOWN OR LOCATION: BALTO
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2811 FAIT AVE.
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5TH; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): FRANCISZEK SOBCZAK
18. MOTHER'S NAME (First, Middle, Maiden Surname): JOSEPHINE MACKOWIAK
19a. INFORMANT'S NAME (Type/Print): IRENE PINTI
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2811 FAIT AVE BALTO MD. 21224
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HOLY ROSARY CEMETERY
20c. LOCATION — City or Town, State: BALTO. MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: David L. Weber
22. NAME AND ADDRESS OF FACILITY: JOHN M. WEBER & SONS INC, 401 S. CHESTER ST.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIOPULMONARY ARREST | MINUTES |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: AORTIC STENOSIS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Jorge C. Secada Lovio, MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year) ▶ 4-16-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JORGE C. SECADA-LOVIO, MD. CHURCH HOSPITAL, BALTIMORE, MD 21231
31. DATE FILED (Month, Day, Year): APR 24 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 11311

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11312
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. [illegible] should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| CLARENCE | FRANK | ROONEY | 4 / 15 / 89 | 6:56 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-09-7114 | 1 [X] M 2 [ ] F | 87 YRS. | | | 7/28/01 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| University Hospital | Baltimore | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | | Baltimore | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1104 Carroll Street | 21230 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 5th grade | | Sheet Metal | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Unknown | Unknown |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Bruce Raeke | 1104 Carroll Street Baltimore, Md. 21230 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Loudon Park Cemetery | Baltimore, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| [signature] | Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [X] YES 2 [ ] NO |
| Partial | |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | OCME | ▶ 4-16-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Julia C. Goodin, M.D. 111 Penn St., Balto., MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 20 1989 | [signature] |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11313
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Troy A. Roth | | | | 2. DATE OF DEATH: MONTH 4-22-89 DAY YEAR | 3. TIME OF DEATH: 3:35PM M |
| 4. SOCIAL SECURITY NUMBER: 192-62-0934 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 20 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Oct12 1968 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): University Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Penn. | 10b. COUNTY: York | 10c. CITY, TOWN OR LOCATION: Conewago | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 875 Buck Road | | 10f. ZIP CODE: 17315 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction Worker | 16b. KIND OF BUSINESS/INDUSTRY: Bridges | |
| 17. FATHER'S NAME (First, Middle, Last): Stanley Roth | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Brenda Crone | |
| 19a. INFORMANT'S NAME (Type/Print): Stanley Roth | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 875 Buck Rd. Dover, Pennsylvania 17315 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Memorial Gardens | 20c. LOCATION — City or Town, State: Dover Pennsylvania |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William E. Johnson | | 22. NAME AND ADDRESS OF FACILITY: William E. Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21204 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple injuries — DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ___ DUE TO (OR AS A CONSEQUENCE OF):

c. ___ DUE TO (OR AS A CONSEQUENCE OF):

d. ___

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? X YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? X YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? X YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 X Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 4-18-89 | 28b. TIME OF INJURY: 6:09AM | 28c. INJURY AT WORK? 1 ☐ YES 2 X NO | 28d. DESCRIBE HOW INJURY OCCURED: Driver in auto/tractor trailer impact |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): road | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): I-83, Cockeysville, MD |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A. Korell, M.D. | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 4-23-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. | | 111 Penn Street, Baltimore, MD 21201 |
| 31. DATE FILED (Month, Day, Year): APR 24 1989 | 32. REGISTRAR'S SIGNATURE: Julia Gordon-Randall | |

DHMH-16 Rev 1/89

12 VC

98 11313

89 11314

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Harry E. Rust | | | 2. DATE OF DEATH (Month, Day, Year): 4-12-89 | 3. TIME OF DEATH: 12:42PM M |
| 4. SOCIAL SECURITY NUMBER: 217-14-9604 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 67 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 3/28/22 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore,City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Arbutus | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 1113 Flamingo Drive | | 10f. ZIP CODE: 21227 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic | 16b. KIND OF BUSINESS/INDUSTRY: Amstar, INc. | |
| 17. FATHER'S NAME (First, Middle, Last): Levi Rust | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Hilda Lundquist | |
| 19a. INFORMANT'S NAME (Type/Print): Goldie S. Rust | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1113 Flamingo Dr. Baltimore, Maryland 21227 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Louis P. Smith | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, INc. 4107 Wilkens Avenue Baltimore, Md. 21229 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO INQUIRY | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle,Jr.M.D. | 29c. LICENSE NUMBER: CCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-13-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle,Jr.M.D. 111 Penn Street,Baltimore,MD 21201 VC | | |
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Landers | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11315
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 (this) should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANDERSON Redd
2. DATE OF DEATH: MONTH 4 DAY 27 YEAR 89
3. TIME OF DEATH: 1117p M
4. SOCIAL SECURITY NUMBER: 205-07-8943
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 81 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 01/02/1908
8. BIRTHPLACE (State or Foreign Country): Va
9a. FACILITY NAME (If not institution, give street and number): Harbor Cedar Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Balt City

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: A. A. Co.
10c. CITY, TOWN OR LOCATION:
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 6006 Bella Grove Rd
10f. ZIP CODE: 21225
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 8 College (1-4 or 5+):
15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Track Man
16b. KIND OF BUSINESS/INDUSTRY: Railroad
17. FATHER'S NAME (First, Middle, Last): Charles Redd
18. MOTHER'S NAME (First, Middle, Maiden Surname): Olivia Redd
19a. INFORMANT'S NAME (Type/Print): Mabel Redd
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6006 Bella Grove Rd Balt MD 21225
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery
20c. LOCATION — City or Town, State: Brooklyn Park, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lena Gibson Funeral Home
22. NAME AND ADDRESS OF FACILITY: 1635 Pleasant Hill Ave Balt MD 21217

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hepatic Encephalopathy
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Liver metastases (Adenocarcinoma) 2/88
DUE TO (OR AS A CONSEQUENCE OF):
c. Primary Prostate Carcinoma 2/88.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Tzehan Wong (House officer)
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 04/27/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TZEHAN WONG 3001 S. HANOVER ST. BALT. MD 21230.
31. DATE FILED (Month, Day, Year): MAY 4 1989
32. REGISTRAR'S SIGNATURE: L. Lin Davidson-Randall

DHMH-15 Rev 1/89

89 11316

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CHARLES RHODES | | 2. DATE OF DEATH (Month, Day, Year): APRIL 23, 1989 | 3. TIME OF DEATH: 8:00 p M |
| 4. SOCIAL SECURITY NUMBER: 216-28-8352 | 5. SEX: X 1 M 2 F | 6. AGE (In yrs. last birthday): 56 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10-20-32 |
| 8. BIRTHPLACE (State or Foreign Country): MD. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): MARYLAND GENERAL HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: BALTIMORE CITY | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: Baltimore City | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| 10e. STREET AND NUMBER: 333-35 S.Freemont Ave. Apt I 21230 | | 10f. ZIP CODE: 21230 | 10g. CITIZEN OF WHAT COUNTRY? USA. |
| 11. MARITAL STATUS: 1 Never Married 2 Married 3 X Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): Aaron Rhodes | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Irene Johnson | |
| 19a. INFORMANT'S NAME (Type/Print): Debra Rhodes | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 333-35 S.Freemount Ave. Apt.I 21230 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt.Auburn Cemetery | 20c. LOCATION — City or Town, State: Westport MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Cecil A Estep | | 22. NAME AND ADDRESS OF FACILITY: Estep Brothers Funeral Home. 1300 Eutaw Pl. Balto MD. 21217 | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SUSPECTED ESOPHAGEAL BLEED | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. HYPOTENSIVE SHOCK | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. END-STAGE LIVER DISEASE AND ENCEPHALOPATHY | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | |
| 27. MANNER OF DEATH: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 YES 2 NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Hadi M.D. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 4/23/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HUSSEIN ABDUL-HADI M.D. | | |
| 31. DATE FILED (Month, Day, Year): APR 27 1989 | 32. REGISTRAR'S SIGNATURE: Julia Dorsey-Randall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11317
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): James A Randolph | | 2. DATE OF DEATH (Month, Day, Year): 4 24 89 | 3. TIME OF DEATH: 920 PM |
| 4. SOCIAL SECURITY NUMBER: 228 30 1856 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12/4/1927 |
| 8. BIRTHPLACE (State or Foreign Country): Va. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key | 9b. CITY, TOWN OR LOCATION OF DEATH: Balto. | 9c. COUNTY OF DEATH: none | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Balto. | 10c. CITY, TOWN OR LOCATION: Turners Station | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 106 Chestnut Street | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [XX] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [XX] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bethlehem Steel | 16b. KIND OF BUSINESS/INDUSTRY: Steel | |
| 17. FATHER'S NAME (First, Middle, Last): Freeman Randolph | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Craddock | | |
| 19a. INFORMANT'S NAME (Type/Print): Shirley Randolph | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 106 Chestnut St. Balto., Md. 21222 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Family Plot | 20c. LOCATION — City or Town, State: Crewe, Va. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James A. Morton | 22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons 1701 Laurens St. Balto., Md. 21217 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Respiratory Arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Cardiac Arrest | 1 HR |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Neurologic Sequela | 1 WEEK |
| d. | Previous Cardiopulmonary Arrest | 1 WEEK |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] ND | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] ND |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] ND |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/24/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) | | |
| 31. DATE FILED (Month, Day, Year): APR 26 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Lindsay | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11318
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BERTHA M. ROBERTS | | | 2. DATE OF DEATH: MONTH 4 DAY 30 YEAR 1989 | 3. TIME OF DEATH: 2240 M |
| 4. SOCIAL SECURITY NUMBER: 214-22-9491 | 5. SEX: 1 ☐ M 2 ☒ F XX | 6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3-23-1901 | 8. BIRTHPLACE (State or Foreign Country): VIRGINIA |
| 9a. FACILITY NAME (If not institution, give street and number): HARBOR VIEW HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6612 BUSHEY STREET | 10f. ZIP CODE: 21224 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 TH GRADE; College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last): JAMES ROBERTS | 18. MOTHER'S NAME (First, Middle, Maiden Surname): NARCISSUS PAGE | | |
| 19a. INFORMANT'S NAME (Type/Print): IRIS G. McKAY | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6612 BUSHEY STREET BALTIMORE, MARYLAND 21224 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OAK LAWN CEMETERY MAY 4, 1989 | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MARYLAND 21222 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Malignant Ventricular Arrhythmia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Recent Myocardial Infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Ikeadi M. Ndukwe, MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/30/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ikeadi M. Ndukwe, MD Harbor Hospital Center, Baltimore, MD | | |
| 31. DATE FILED (Month, Day, Year): MAY 3 - 1989 | 32. REGISTRAR'S SIGNATURE: [signature] | |

DHMH-16 Rev 1/89

88 11318

JUANITA JUNE RAAB

89 11319

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JUNE J RAAB
2. DATE OF DEATH (Month, Day, Year): 4 26 89
3. TIME OF DEATH: 915 P M
4. SOCIAL SECURITY NUMBER: 213-05-7296
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): SEPT. 2 1917
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not Institution, give street and number): U of Maryland Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 6103 ALTA AVE
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 YRS. — College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): AT HOME
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Samuel Webster
18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna MCElwee
19a. INFORMANT'S NAME (Type/Print): Charles Gallatin
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3220 E Northern Pkwy, Balt, Md 21214
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARDENS OF FAITH
20c. LOCATION — City or Town, State: ROSEDALE
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] & Evans
22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiopulmonary arrest
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. acute respiratory distress syndrome — 3 days
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: L. A. Cooper MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 4/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): L. A. Cooper MD., 22 S. Greene St. Baltimore, Md 21201
31. DATE FILED (Month, Day, Year): MAY 2 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11320
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pgs. 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RICHARD ROWE | | 2. DATE OF DEATH (Month, Day, Year): 4 22 89 | 3. TIME OF DEATH: 10:36 PM |
| 4. SOCIAL SECURITY NUMBER: 318-42-6900 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 42 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 5-7-46 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Bon Secour Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 903 W. Saratoga St. | | 10f. ZIP CODE: 21223 | 10g. CITIZEN OF WHAT COUNTRY? US |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): Vincent Rowe | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Carrie Rowe | |
| 19a. INFORMANT'S NAME (Type/Print): Carrie Rowe | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 903 W. Saratoga St. Balto, MD 21223 | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn | 20c. LOCATION — City or Town, State: Woodlawn, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: Irvin Carroll Funeral Home 1712-14 W. North Avenue | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Pulmonary failure | Min |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Acute Pulmonary edema | 2 days. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | COPD. | years. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DRUG OVERDOSE

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature], MD | 29c. LICENSE NUMBER: D23276 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-25-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. MIRANDA, MD 1010 ST. PAUL ST. Balto, Md 21202 | | |
| 31. DATE FILED (Month, Day, Year): APR 25 1989 | 32. REGISTRAR'S SIGNATURE: [signature] | |

DHMH-16 Rev 1/89

89 11321

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LYNDIA E. RANDALL | | | 2. DATE OF DEATH (Month / Day / Year): 04 / 23 / 89 | 3. TIME OF DEATH: 9 P M |
| 4. SOCIAL SECURITY NUMBER: 215-52-0971 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 40 YRS. (If under 1 year: Months; If under 24 hrs.: Days, Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 2-9-49 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): FRANCIS SCOTT KEY MED CTR | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH: BALTIMORE | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4831 ABERDEEN AVENUE | 10f. ZIP CODE: 21206 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): HIGH SCHOOL; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): L.P.N. | 16b. KIND OF BUSINESS/INDUSTRY: NA | |
| 17. FATHER'S NAME (First, Middle, Last): BRISCO MASON | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARYLAND | | |
| 19a. INFORMANT'S NAME (Type/Print): BERTA MITCHELL | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1362 Pentridge Road/Baltimore, MD. 21239 | | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY | 20c. LOCATION — City or Town, State: ANNE ARUNDEL CO., MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Francis Shaw | 22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ANOXIC BRAIN DAMAGE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. "SUDDEN DEATH" Cardiac arrest | 5days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. SEVERE PULMONARY EDEMA. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. SEVERE CORONARY ARTERY DISEASE. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: md | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/23/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BRIAN LEWIS, MD., FSKMC | | |
| 31. DATE FILED (Month, Day, Year): APR 25 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landrum | |

DHMH-15 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11322
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Agnes J. Romero | | | 2. DATE OF DEATH (Month, Day, Year): Apr. 23, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 205-16-6390 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Oct. 01, 1910 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Eastpoint Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: Baltimore City | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 8 N. Belnord Ave. | | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Unknown Kokoszka | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Wilks | |
| 19a. INFORMANT'S NAME (Type/Print): Edward Rogowski | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4915 Sinclair LaneBaltimore Md 21213 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hilly Hills Cemetery | 20c. LOCATION — City or Town, State: Chase, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ David J. Weber | 22. NAME AND ADDRESS OF FACILITY: John M. Weber & Sons 401 S. Chester St. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIOPULMONARY ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CORONARY ARTERY DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. CONGESTIVE HEART FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. CHRONIC OBSTRUCTIVE LUNG DISEASE | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 5 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 5 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Savinder K Tulka MD | 29c. LICENSE NUMBER: D27188 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/24/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SAVINDER K TULKA 2900 DUNRAM ROAD BALTIMORE MD 21222

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 27 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rudasill |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EARL E. ROHRMAN | | 2. DATE OF DEATH (Month, Day, Year): 4-28-89 | 3. TIME OF DEATH: 7:40 p M |
| 4. SOCIAL SECURITY NUMBER: 218-14-9979 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8-09-24 |
| 8. BIRTHPLACE (State or Foreign Country): Baltimore | | | |
| 9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 529 S CHAPEL ST | | 10f. ZIP CODE: 21231 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5+): -- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Ernest Rohrman | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Andrea Webb | |
| 19a. INFORMANT'S NAME (Type/Print): Darlene Rohrman | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 529 S. Chapel St./ Baltimore, Md. 21231 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery | 20c. LOCATION — City or Town, State: Baltimore | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Elizabeth A. Dowell | 22. NAME AND ADDRESS OF FACILITY: Lilly & Zeiler, Inc. Funeral HOmes 1901 Eastern Avenue Baltimore, MD 21231 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arrest ARREST POSSIBLE MASSIVE AINTI MI | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Possible massive Ainti MI | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Bena Nagpal NAGPAL, BENA | 29c. LICENSE NUMBER: D30639 | 29d. DATE SIGNED (Month, Day, Year) ▶ | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHURCH HOSPITAL | | | |
| 31. DATE FILED (Month, Day, Year): MAY 2 - 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Registrar | | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James Robinson
2. DATE OF DEATH (Month, Day, Year): April 10, 1989
3. TIME OF DEATH: 8:10 p. M
4. SOCIAL SECURITY NUMBER: 219-26-1470
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 77 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 9-2-1911
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Maryland General HOspital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

**RESIDENCE OF DECEDENT**

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: Franklin Court Nursing Home
10f. ZIP CODE: 212
10g. CITIZEN OF WHAT COUNTRY? U.S.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):
16a. OECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Unemployed
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Jerry Robinson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Caroline
19a. INFORMANT'S NAME (Type/Print): Franklin Court Nursing H
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code):
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion
20c. LOCATION — City or Town, State: Baltimore Co
21. SIGNATURE OF FUNERAL SERVICE LICENSEE:
22. NAME AND ADDRESS OF FACILITY: Irvin Carroll Funeral Home 1712-14 W. North Avenue

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. METABOLIC ACIDOSIS
DUE TO (OR AS A CONSEQUENCE OF):
c. GASTROINTESTINAL BLEEDING
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DECUBITUS ULCER
DIABETES MELLITUS

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Patrick Kin-Yee Chau MD
29c. LICENSE NUMBER: N/A
29d. DATE SIGNED (Month, Day, Year): 4/10/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Patrick Kin-Yee Chau C/O Maryland General Hospital
31. DATE FILED (Month, Day, Year): APR 18 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Kelvin R. Robinson
2. DATE OF DEATH (Month, Day, Year): 4 29 89
3. TIME OF DEATH: 128 P M
4. SOCIAL SECURITY NUMBER: 215-78-5890
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 24 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 6.7.64
8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimae
10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1703 E. 25th St.
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY? U.S.A
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer
16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): Thomas Robinson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Manuel
19a. INFORMANT'S NAME (Type/Print): Bertha Robinson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1703 E. 25th Street/Balto. MD 21213
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Cem.
20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: 1101 E. North Ave. William C. March F.H

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | bilateral tentorial herniation | 6 d. |
| DUE TO (OR AS A CONSEQUENCE OF): b. | & intracranial hemorrhage | 3 d. |
| DUE TO (OR AS A CONSEQUENCE OF): c. | cerebral aneurysm | ? congenital vs. 2° to SBE |
| DUE TO (OR AS A CONSEQUENCE OF): d. | subacute bacterial endocarditis | up to 5 mo. |

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: possible Marfans Syndrome

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Walter J. Straus MD
29c. LICENSE NUMBER: 17738 8274
29d. DATE SIGNED (Month, Day, Year): ▶ 4/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ANNE STOLINE FRANCIS SCOTT KEY HOSPITAL
31. DATE FILED (Month, Day, Year): 4/29/89
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME: FIRA ROZETTI | | 2. DATE OF DEATH (Month, Day, Year): 4/27/89 | 3. TIME OF DEATH: 11:20 PM |
| 4. SOCIAL SECURITY NUMBER: 214905622 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 83 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): MARCH 8, 1906 |
| 8. BIRTHPLACE (State or Foreign Country): RUSSIA | | | |
| 9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTO. | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3601 FORDS LANE, APT. 510 | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: AT HOME |
| 17. FATHER'S NAME (First, Middle, Last): AARON SHOLMO KOTLAZERKO | 18. MOTHER'S NAME (First, Middle, Maiden Surname): BLUMA UNKNOWN | |
| 19a. INFORMANT'S NAME (Type/Print): MARKUS ROZETTI | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4041 CARTHAGE RD. RANDALLSTOWN, MD 21133 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHIZUK AMUNO CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellenore Levinson | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIAC ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): SEPSIS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | HOUSE STAFF | ▶ 4/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHERYL TAYLOR, SINAI HOSP, BALT

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 2 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EONA ROLKER | | | 2. DATE OF DEATH: MONTH 4 DAY 24 YEAR 89 | 3. TIME OF DEATH: 7:40 PM |
| 4. SOCIAL SECURITY NUMBER: 219-22-7703 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 96 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2-24-1893 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Church Home | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: -0- |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: -0- | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4412 Marble Hall Road | | 10f. ZIP CODE: 21218 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): M.A.-JHU '24 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher/Principal | 16b. KIND OF BUSINESS/INDUSTRY: Education |
| 17. FATHER'S NAME (First, Middle, Last): Herman Rolker | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Caroline Diering | |
| 19a. INFORMANT'S NAME (Type/Print): Elizabeth A. Pearce | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16513 Killdeer Dr., Rockville, Md. 20855 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | 20c. LOCATION — City or Town, State: Baltimore City Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph J. W. Kellner | | 22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Directors, INC. 8728 Liberty Road Randallstown, MD 21133-4784 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CHF | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Mitral Regurgitation | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. ASCVD | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Corazon Vergara-Soares | 29c. LICENSE NUMBER: D 16619 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-25-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Corazon Vergara-Soares 100 N. Broadway Baltimore MD. 21231 | | |
| 31. DATE FILED (Month, Day, Year): APR 28 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

23

DHMH-16 Rev 1/89

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RITZ, ANTHONY J
06/06/38 M

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11328
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| ANTHONY | JOSEPH | RITZ | APRIL 28, 1989 | 5:03A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 532-38-6734 | 1 [X] M 2 [ ] F | 50 YRS. | | | 6/6/38 | MASS. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. [illegible] |
|---|---|---|
| THE JOHNS HOPKINS HOSPITAL | BALTIMORE CITY | BALTIMORE |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | HOWARD | COLUMBIA | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 5354 THUNDERHILL RD. | 21045 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES 1958-1962 | 1 [ ] YES 2 [X] NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | 5+ | VOCATIONAL REHABILITATION | VETERANS ADMINISTRATION |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| ANTHONY A. RITZ | TERESA CASSESE |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MAUREEN RITZ | 5354 THUNDERHILL RD. COLUMBIA, MD. 21045 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____ | MD. VETERANS CEMETERY GARRISON FOREST | OWINGS MILLS MD. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| [signature] | 5555 TWIN KNOLLS RD. COLUMBIA, MD. 21045 LEROY M. & RUSSELL C. WITZKE FUNERAL HOME |

TO BE COMPLETED BY PHYSICIAN; MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Intern Med | 1 hours |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Lung Ca | 1 yr. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [X] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Philip Kerr MD | D36904 | ▶ 4/28/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
600 N. Wolfe St. / Balto. MD. 21205 J.H.H.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 2 1989 | [signature] |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician. The funeral director must obtain a burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for [illegible] and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 11329

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Failure to do so may result in a fine. If signed by the hospital or attending physician, it should be delivered to the funeral director. If signed by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GEORGE L. RAMSBURG (Ramsburg) | | | | 2. DATE OF DEATH (Month, Day, Year): 04 07 89 | 3. TIME OF DEATH: 5:05 PM |
| 4. SOCIAL SECURITY NUMBER: 219147520 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 78 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 07, 26, 10 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: City | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: CARROLL | 10c. CITY, TOWN OR LOCATION: Sykesville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: MAIN Street | | 10f. ZIP CODE: 21784 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNK; College (1-4 or 5+): UNK | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): [redacted] Taxi Driver | 16b. KIND OF BUSINESS/INDUSTRY: [redacted] Driving | |
| 17. FATHER'S NAME (First, Middle, Last): [redacted] Clayton R. Ramsburg | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): UNK Kolb | |
| 19a. INFORMANT'S NAME (Type/Print): Springfield Hospital Records | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Sykesville, Md- 21784 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Olivet Cemetery | 20c. LOCATION — City or Town, State: Frederick, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry W. Haight | 22. NAME AND ADDRESS OF FACILITY: Haight Funeral Home Sykesville, Md. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SEPTIC SHOCK | 3 DAYS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 X NO | 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD HOUSESTAFF | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 04/07/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SANY T. KHABBAZ M.D. GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD. BALTIMORE MD 21215 | | | |
| 31. DATE FILED (Month, Day, Year): APR 13 '89 | 32. REGISTRAR'S SIGNATURE: [redacted] | | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11330
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. ... signed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH Month / Day / Year | | 3. TIME OF DEATH |
| Auston Reid RIPPEON | | | | April 12 | 1989 | 7:25 PM |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTHPLACE (State or Foreign Country) |
| 705 12 5457 | 1 [X] M 2 [ ] F | 70 YRS. | 5 / 22 | Oct. 20, 1918 | | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| V.A. Hospital | Baltimore City | Baltimore |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Carroll | Woodbine | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 7639 Woodbine Road | 21797 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW 2 | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 8 +) | | |
| 7 years | None | Carpenter | Construction |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Manley R. Rippeon | Mary A. Greene |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary Louise Rippeon | 7639 Woodbine Rd. Woodbine, Md. 21797 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Poplar Springs Cemetery | Poplar Springs, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Charles B. Burrier, Jr. | Burrier Funeral Home Sykesville, Maryland 21784 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIAC ARRHYTHMIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ISCHEMIC DILATED CARDIOMYOPATHY | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending investigation 8 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| James A. Dicke, MD | D36231 | ▶ 4/12/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JAMES A. DICKE, MD DEPT. OF MED GREENE ST. BALTO. MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 13 '89 | Jane Davidson-Randall |

DHMH-16 Rev 1/89

88 11330

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11331
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARGARET K. RODWELLER | | | 2. DATE OF DEATH (Month, Day, Year): 04 25 1989 | 3. TIME OF DEATH: 6:20 a M |
| 4. SOCIAL SECURITY NUMBER: 214-02-0050 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Apr. 16, 1909 | 8. BIRTHPLACE (State or Foreign Country): New Jersey |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: ----- |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Dundalk | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1344 Willow Road | | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): James Kennedy | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Fagen | |
| 19a. INFORMANT'S NAME (Type/Print): William Rodweller | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1344 Willow Road, Baltimore, MD 21222 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery 4/28/89 | 20c. LOCATION — City or Town, State: Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Chas W. Fisher | | 22. NAME AND ADDRESS OF FACILITY: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Baltimore, MD 21222 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Septic Shock

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph Tomarelli MD | 29c. LICENSE NUMBER: D37030 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/25/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph Tomarelli MD 1E University Pkwy Balt Md. | | |
| 31. DATE FILED (Month, Day, Year): APR 28 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

1

DNMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11332

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MD 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be ... al or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page ... for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be ...**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELMER R. REIGHARD | | | 2. DATE OF DEATH (Month, Day, Year): 4 26 89 | 3. TIME OF DEATH: 6 10 AM |
| 4. SOCIAL SECURITY NUMBER: 177-07-7673 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 81 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8-29-1907 |
| 8. BIRTHPLACE (State or Foreign Country): Pennsylvania | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Dundalk | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 113 Kinship Road, Apt. 1-A | | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): | 15e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Crane Operator | 16b. KIND OF BUSINESS/INDUSTRY: Bethlehem Steel | |
| 17. FATHER'S NAME (First, Middle, Last): Not known Reighard | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Mischler | |
| 19a. INFORMANT'S NAME (Type/Print): Dolores J. Reighard | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1316 Willow Road Baltimore, MD 21222 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Bel Air Memorial Park 4/29/89 | 20c. LOCATION — City or Town, State: Bel Air, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Scott P. Hardesty | 22. NAME AND ADDRESS OF FACILITY: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Baltimore, MD 21222 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. respiratory failure | 24 H |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. presumed post-obstructive pneumonia | 4 D |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. presumed lung cancer | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

~~car~~ atherosclerosis

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 5 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D08457 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/26/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A STOLINE, MD FSK Medical Center | | |
| 31. DATE FILED (Month, Day, Year): APR 28 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11333
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROSENBERG, MINNIE MINNIE ROSENBERG | | 2. DATE OF DEATH: MONTH 4 DAY 29 YEAR 89 | 3. TIME OF DEATH: 6:44 PM |
| 4. SOCIAL SECURITY NUMBER: 159-10-9357 | 5. SEX: 1 ☐ M 2 ☒ F | 5. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12/15/1906 |
| 8. BIRTHPLACE (State or Foreign Country): ENGLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6807 PARK HEIGHTS AVE. | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 GRADE; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BOOKKEEPER | 16b. KIND OF BUSINESS/INDUSTRY: SHOENEMANS, MENS CLOTHING | |
| 17. FATHER'S NAME (First, Middle, Last): UNKNOWN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): SALFAS UNKNOWN | |
| 19a. INFORMANT'S NAME (Type/Print): THE IRA KAUFMAN CHAPEL | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18325 W. NINE MILE RD. SOUTHFIELD, MI. ( 48075) | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CLOVERHILL PARK | 20c. LOCATION — City or Town, State: BIRMINGHAM, MI. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215) | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. MULTI-SYSTEM ORGAN FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. MYOCARDIAL INFARCTION - CARDIOGENIC SHOCK | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Sepsis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. PERFORATED VISCUS | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | 15240232 I IW-GYN | ▶ 4/29/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): IAN M. WEINER M.D. - SINAI HOSP.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 2 1989 | Julia Davidson-Randall |

DHMH-15 Rev 1/89

88 11333

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11334
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Joshua Harvey Raver, Sr. | | 2. DATE OF DEATH (Month, Day, Year): 4-4-89 | 3. TIME OF DEATH: 6:30AM M |
| 4. SOCIAL SECURITY NUMBER: 218-32-7141 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 53 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11-4-35 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 1900 Alicanna Street | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Reisterstown | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 100 Neel Ave. | 10f. ZIP CODE: 21136 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1954 - 1957 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: X | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales Supervisor | 16b. KIND OF BUSINESS/INDUSTRY: Schmidt Baking Company | |
| 17. FATHER'S NAME (First, Middle, Last): H. Ellsworth Raver Sr. | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Francis N. Harvey | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Joanne G. Raver | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 Neel Ave. Reisterstown, Md. 21136 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veterans Cem. | 20c. LOCATION — City or Town, State: Owings Mills, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Frank Eline | 22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home Reisterstown, Md. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Multiple injuries
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) workplace

27. MANNER OF DEATH: 1 [ ] Natural [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): 4-4-89
28b. TIME OF INJURY: 6:20AM M
28c. INJURY AT WORK? 1 [X] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED: Pinned between car & truck
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): workplace
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1900 block Aliceanna Street

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ 4-4-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan, M.D. 111 Penn Street, Baltimore, MD 21201 VC

31. DATE FILED (Month, Day, Year): APR 11 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11335 REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HENRY G. ROEDER | | | 2. DATE OF DEATH (Month, Day, Year): 4-2-89 | 3. TIME OF DEATH: 930 AM |
| 4. SOCIAL SECURITY NUMBER: 212-05-0610 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 01/06/06 | 8. BIRTHPLACE (State or Foreign Country): md |
| 9a. FACILITY NAME (If not institution, give street and number): St Joseph Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | 9c. COUNTY OF DEATH: Baltimore County | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: md | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore city | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2918 Harview Ave | | 10f. ZIP CODE: 21234 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Switchboard Technician | 16b. KIND OF BUSINESS/INDUSTRY: C & P Telephone |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): George Roeder | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Scheele |
| 19a. INFORMANT'S NAME (Type/Print): Eleanor Roeder | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2918 Harview Ave., Baltimore, MD 21234 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Park | 20c. LOCATION — City or Town, State: Baltimore, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. George Altenburg | 22. NAME AND ADDRESS OF FACILITY: ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Francis Thaddeus Khoo, MD | 29c. LICENSE NUMBER: D 30263 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-2-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANCIS T. KHOO - St. Joseph Hospital

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 4 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

88 11332

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11336
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Rosalee Rocusin | | | 2. DATE OF DEATH (Month, Day, Year): 4 1 89 | 3. TIME OF DEATH: 335p M |
| 4. SOCIAL SECURITY NUMBER: 213-48-0532 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9/6/08 | 8. BIRTHPLACE (State or Foreign Country): VIRGINIA |

9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL of BALTIMORE Belvedere at Greenspring AVE
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6317 Park Heights Ave Apt 318 | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEIWFE | 16b. KIND OF BUSINESS/INDUSTRY: AT HOME | |
| 17. FATHER'S NAME (First, Middle, Last): NATHAN SHEVITZ | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): BESSIE ROCHKIND | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. THELMA S. SINSKY | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2416 VELVET VALLEY WAY OWINGS MILLS, MD 21117 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): AHAVAS SHALOM | 20c. LOCATION — City or Town, State: ROSEDALE, BALTO., MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellenore Levinson | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiopulmonary arrest | 3/31/89 |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | probable Ventricular rupture | 4/1/89 |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | acute myocardial infarct | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☒ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Michele J. Gollub MD | 29c. LICENSE NUMBER: D35819 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-1-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michele J. Gollub MD Asst. Chief Resident | Belvedere at Greenspring | SINAI HOSPITAL Baltimore MD 21215 |
| 31. DATE FILED (Month, Day, Year): 4-1-89 APR 07 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DOROTHEA E. ROSE

89 11337

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Rose | Dorothea E | Rose | 4 4 89 | 425 a M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214 14 2377 | 1 ☐ M 2 ☒ F | 68 YRS. | | | JAN 23, 1921 | MARYLAND |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Union Memorial Hospital | Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | BALTIMORE | PARKVILLE, MARYLAND | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 4 TERRON COURT | 21234 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 8 YRS. | | SELF EMP. | HAIRDRESSER |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| RICHARD NORWOOD | EVELYN BAIRD |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| FAMILY RECORDS | SAME AS ABOVE |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | PARKWOOD CEMETERY | PARKVILLE MD. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ [signature] | EVANS CHAPEL OF MEMORIES 8500 HARFORD ROAD - PARKVILLE |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. MI | |
| | OUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Ischemic cardiomyopathy | |
| | OUE TO (OR AS A CONSEQUENCE OF): | |
| | c. 2° to severe CAD + Peripheral vasc. disease | |
| | OUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Vincent Wroblewski, MD | | ▶ 4/4/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Vincent P Wroblewski, MD - Union Memorial Hospital Balto. Md

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 6 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

88 11331

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11338

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

4

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Barbara Ann Rathbun | | | | 2. DATE OF DEATH (Month, Day, Year): 04 02 89 | 3. TIME OF DEATH: 4:15 PM |
| 4. SOCIAL SECURITY NUMBER: 218-26-5538 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 56 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 6/8/1932 | 8. BIRTHPLACE (State or Foreign Country): New Jersey |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: -- |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: --- | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 722 Pontiac Avenue | | 10f. ZIP CODE: 21225 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Domestic |
| 17. FATHER'S NAME (First, Middle, Last): Arthur King | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Nina Hudson | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Mary Burrs | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 722 Pontiac Ave., Baltimore, Maryland 21225 | |
| 20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery | 20c. LOCATION — City or Town, State: Essex, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ K E E | Kevin E. Ecker | 22. NAME AND ADDRESS OF FACI: McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Baltimore, Md. 21225 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Multiple CVA | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Urosepsis | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 25. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] M.D | | ▶ 4/2/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ANDRE BRUTUS MD 3001 S. Hanover St Baltimore MD 21230

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 4 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/88

88 11338

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11339
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROY H. RITTER | | | | | 2. DATE OF DEATH: MONTH 4 DAY 4 YEAR 89 | 3. TIME OF DEATH: 3:52 P M |
| 4. SOCIAL SECURITY NUMBER: 214-03-6783 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 85 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3/12/04 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Roland Park Place | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: Balto. City | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Balto. City | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 830 West 40th. Street | 10f. ZIP CODE: 21211 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 5+ Yrs | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineer | 16b. KIND OF BUSINESS/INDUSTRY: Whitman Assoc. |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Charles Ritter | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucy Siegfried |
| 19a. INFORMANT'S NAME (Type/Print): Willis Ritter | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1156 15th St. N.W. Washington D.C. 20005 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount Cemetery 4/6/89 | 20c. LOCATION — City or Town, State: Balto. Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ronald E Ruck Sr. | 22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Acute CVA (Stroke) | 7D |
| DUE TO (OR AS A CONSEQUENCE OF): | CVA (Stroke) | 9M |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | | |
| DUE TO (OR AS A CONSEQUENCE OF): c. | ASCVD | 20 yrs |
| DUE TO (OR AS A CONSEQUENCE OF): d. | ATRIAL FIBRILLATION | 10 yrs |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) — | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) — |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Gregory J Walker MD | 29c. LICENSE NUMBER: MD / D25L 62 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gregory Walker M.D. 3300 N. Calvert St. 21218

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 7 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson Registrar |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11340

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Frank | E. | Robinson | 4-6-89 | 7:00PM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-01-4096 | 1 [X] M 2 [ ] F | 83 YRS. | | | 3/30/06 | VA. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 2108 Whittier Avenue | Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | | BALTIMORE CITY | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 2108 WHITTIER AVENUE | 21217 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 6th Grade | | EDGEWOOD ARSEN. | NA. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| EUGENE JACK ROBINSON | FLORENCE E. VAUGHN |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JOHN L. SMITH | 3631 WABASH AVENUE/BALTIMORE, MD. 21215 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | MARYLAND NAT'L PK. CEM | LAUREL, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| [signature] | WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute aortic dissection | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Hypertensive arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [X] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | OCME | ▶ 4-7-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 11 1989 | [signature] |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11341

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John E. Robinson
2. DATE OF DEATH (Month / Day / Year): 4 / 3 / 89
3. TIME OF DEATH: 10:50 AM
4. SOCIAL SECURITY NUMBER: 215-28-6464
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 56 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 01-31-33
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Homewood Hospital Center, South
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: N/A
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? XX 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2537 N. Aisquith Street
10f. ZIP CODE: 21218
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: 3/23/53 - 3/11/55
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Negroid
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th grade — College (1-4 or 5+): none
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic
16b. KIND OF BUSINESS/INDUSTRY: Amstar Corporation
17. FATHER'S NAME (First, Middle, Last): Leroy Robinson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Lane
19a. INFORMANT'S NAME (Type/Print): Serena Robinson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2537 N. Aisquith Street/Balto. Md. 21218
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest
20c. LOCATION — City or Town, State: Owings Mills, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin B. Scruggs Sr.
22. NAME AND ADDRESS OF FACILITY: Calvin B. Scruggs Funeral Home, 1412 E. Preston St. Balto, Md. 21213

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Sepsis | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. | Aspiration Pneumonia | |
| DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
(1) atherosclerotic Cardiovascular Disease w/ Recent Myocardial infarction
(2) Urinary tract infection
(3) Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Marcos B. Galicia MD
29c. LICENSE NUMBER: D15698
29d. DATE SIGNED (Month, Day, Year): ▶ 4/3/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARCOS B. GALICIA MD
31. DATE FILED (Month, Day, Year): APR 5 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11342
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lorraine Robb | 2. DATE OF DEATH (Month, Day, Year): 4 9 89 | 3. TIME OF DEATH: 12:10 P M | |
| 4. SOCIAL SECURITY NUMBER: 215-30-9529 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 51 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7. DATE OF BIRTH (Month, Day, Year): 12-1-37 | 8. BIRTHPLACE (State or Foreign Country): MD | | |
| 9a. FACILITY NAME (If not institution, give street and number): 1921 Hoffman Street | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1921 EAST HOFFMAN STREET | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNKNOWN | 16b. KIND OF BUSINESS/INDUSTRY: DISABLED | |
| 17. FATHER'S NAME (First, Middle, Last): DENNIS CHEW | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MILDRED MOODY | | |
| 19a. INFORMANT'S NAME (Type/Print): MILDRED MOORE | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2118 RIDGEHILL AVENUE/BALTIMORE, MD. 21217 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOUNT AUBURN CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald Goetze | 22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cirrhosis of Liver | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Chronic Alcoholism | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO (Partial) | 1 ☒ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Charles P. Kokes MD | OCME | ▶ 4-10-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn St., Balto., Md. 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 10 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11343
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 & 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOHN ROST | | | | 2. DATE OF DEATH (Month, Day, Year): April 5, 1989 | 3. TIME OF DEATH: 10:25 AM |
| 4. SOCIAL SECURITY NUMBER: 217-05-9331 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 83 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Feb. 2, 1906 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Balto. City |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Riviera Beach | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 183 Carroll Road | | 10f. ZIP CODE: 21122 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Tool Repairman | 16b. KIND OF BUSINESS/INDUSTRY: Bethlehem Steel | | | |
| 17. FATHER'S NAME (First, Middle, Last): John Paul Rost | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Beatrice Taylor | | | |
| 19a. INFORMANT'S NAME (Type/Print): Gladys A. Rost | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 183 Carroll Road Riviera Beach, Md. 21122 | | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Westview Memorial Park | 20c. LOCATION — City or Town, State: Westview, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard E Davis | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home | 4001 Ritchie Hwy. Baltimore, Md. 21225 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Seizure disorder | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST: b. Lung carcinoma with brain metastases | DUE TO (OR AS A CONSEQUENCE OF): | |
| c. ✓ | DUE TO (OR AS A CONSEQUENCE OF): | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizure disorder
Esophageal dysmotility

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 5 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Robert Feingold | D37593 | ▶ 4/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT FEINGOLD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 07 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11344
REG. NO.

571

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Paul Edward Rowan | | | 2. DATE OF DEATH (Month, Day, Year): 4-3-89 | 3. TIME OF DEATH: 12:12PM M |
| 4. SOCIAL SECURITY NUMBER: 218-28-0741 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 55 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): July 28, 1933 | 8. BIRTHPLACE (State or Foreign Country): Maryland |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): 2122 E. Baltimore Street | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: Baltimore City |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore City | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? [X] 1 YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2122 E. Baltimore Street | 10f. ZIP CODE: 21231 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Retired 1972 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (1-12): High School; College (1-4 or 5+): College | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): U.S. Government | 16b. KIND OF BUSINESS/INDUSTRY: U.S. Army | |
| 17. FATHER'S NAME (First, Middle, Last): Thomas A. Rowan | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Ellen Morning | |
| 19a. INFORMANT'S NAME (Type/Print): Vera Marley, Sister | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 211 Brookfield Rd., Pasadena, MD 21122 | | |
| 20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MD Veteran Cemetery | 20c. LOCATION — City or Town, State: Crownsville, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Shane Savage | 22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home 3204 Mountain Rd., Pasadena, MD | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Fibrosis of liver with marked fatty change | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Chronic alcoholism | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? [X] 1 YES 2 [ ] NO. Partial | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] 1 YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] 1 YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one). HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [ ] Nursing Home [X] 5 Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: [X] 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO; 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-4-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan, M.D. | 111 Penn Street, Baltimore, MD 21201 VC | |
| 31. DATE FILED (Month, Day, Year): APR 07 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 11345

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DOROTHY RUCKLE | | 2. DATE OF DEATH (Month, Day, Year): 4 / 10 / 1989 | 3. TIME OF DEATH: 8:30Am |
| 4. SOCIAL SECURITY NUMBER: 215-46-7476 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 80 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 12/15/08 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): HOMEWOOD HOSPITAL SOUTH | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: - | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2307 Loretta Avenue | 10f. ZIP CODE: 21223 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: -- | |
| 17. FATHER'S NAME (First, Middle, Last): Walter L. Ruckle | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Minna Poezolt | | |
| 19a. INFORMANT'S NAME (Type/Print): Frances Ruckle | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1119 Gloria Ave. Baltimore, Md. 21227 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jackie D. Shannon | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Myocardial Infarction | 1 week |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D26116 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/10/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): L.D. Harris Homewood Hospital South

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 11 1989 | 32. REGISTRAR'S SIGNATURE: Jackie Davidson-Randall |

DHMH-18 Rev 1/89

89 1345

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11346

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the permit. Unsit items 1-3 on pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): OLA RUCKS
2. DATE OF DEATH (Month, Day, Year): APRIL 1, 1989
3. TIME OF DEATH: 1:35 A M
4. SOCIAL SECURITY NUMBER: 260-22-6348
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 67 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6-2-21
8. BIRTHPLACE (State or Foreign Country): GA
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 924 RUTLAND AVENUE
10f. ZIP CODE: 21205
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): UNKNOWN — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNKNOWN
16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): LUCIUS TERRELL
18. MOTHER'S NAME (First, Middle, Maiden Surname): DOSHIA JONES
19a. INFORMANT'S NAME (Type/Print): DOSHIA TERRELL
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1604 GASDEN DRIVE/ALBANY, GA
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE CEMETERY
20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | pneumonia — DUE TO (OR AS A CONSEQUENCE OF): | 6 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Pulmonary sarcoidosis (End stage) — DUE TO (OR AS A CONSEQUENCE OF): | 12 years. |
| c. | DUE TO (OR AS A CONSEQUENCE OF): | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John A Flynn MD
29c. LICENSE NUMBER: D36733
29d. DATE SIGNED (Month, Day, Year): ▶ 4/1/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jenifer Lutley MD 600 Wolfe Street Johns Hopkins Baltimore MD 21205
31. DATE FILED (Month, Day, Year): APR 5 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-18 Rev 1/89

89 11347

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be completed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): NATALIE A. RUPPRECHT | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 14, 1989 | 3. TIME OF DEATH: 9:00 P M |
| 4. SOCIAL SECURITY NUMBER: 214-19-2470 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 6 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 08 03 82 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: GLEN BURNIE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 8927 TWIN RIDGE DRIVE | | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: U S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 01; College (1-4 or 5+): - | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): STUDENT | 16b. KIND OF BUSINESS/INDUSTRY: LOCAL GOVERNMENT | |
| 17. FATHER'S NAME (First, Middle, Last): HARRY DALE RUPPRECHT JR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CYNTHIA SMITH | |
| 19a. INFORMANT'S NAME (Type/Print): HARRY D. RUPPRECHT JR. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8927 TWIN RIDGE DR. GLEN BURNIE, MD. 21061 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GLEN HAVEN CEMETERY | 20c. LOCATION — City or Town, State: GLEN BURNIE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY S.W. GLEN BURNIE, MD. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cerebrovascular Accident | 78 hrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 26d. DESCRIBE HOW INJURY OCCURED | | |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Steven E. Haun MD; PICU Fellow | 29c. LICENSE NUMBER: D36884 | 29d. DATE SIGNED (Month, Day, Year): 4/14/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Steven E. Haun Johns Hopkins Hosp; 600 N. Wolfe; Baltimore, MD | | |
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | 32. REGISTRAR'S SIGNATURE: [signature] | |

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11348
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Edward Bryan Rockenbaugh | | | | 2. DATE OF DEATH MONTH: 4 DAY: 2 YEAR: 89 | 3. TIME OF DEATH: 7:00 P.M. M | |
| 4. SOCIAL SECURITY NUMBER: 212-03-7491 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 82 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8/15/06 | 8. BIRTHPLACE (State or Foreign Country): Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore city | | 9c. COUNTY OF DEATH: | |
| **RESIDENCE OF DECEDENT** | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Arbutus | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 901 Leeds Avenue | | 10f. ZIP CODE: 21229 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Freight Claim Investagtor | 16b. KIND OF BUSINESS/INDUSTRY: B & O Railroad | | | | |
| 17. FATHER'S NAME (First, Middle, Last): Lee Rockenbaugh | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Nettie Bryan | | | | |
| 19a. INFORMANT'S NAME (Type/Print): Adrenne Rockenbaugh | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 901 Leeds Avenue Baltimore, Maryland 21229 | | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crestlawn Gardens of Mem. | | 20c. LOCATION — City or Town, State: Marriottsville, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jackie N. Shannon | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229 | | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiorespiratory Arrest. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Hypertensive Cardiovascular Dis. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Atherosclerosis. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Peptic ulcer disease.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: X [signature]

29c. LICENSE NUMBER: D 18393

29d. DATE SIGNED (Month, Day, Year): ▶ 4-3-89.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): D.P. Malayaman 4001 Wilkens Avenue Baltimore, Md.

31. DATE FILED (Month, Day, Year): APR 5 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11349
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Lillian Roloff (Middle initial, M.) — LILLIAN ROLOFF

**2. DATE OF DEATH** (Month, Day, Year): 4-2-1989

**3. TIME OF DEATH**: 6:55 P.M.

**4. SOCIAL SECURITY NUMBER**: 213-34-5194

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 87 YRS. (87)

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 9-19-1901

**8. BIRTHPLACE** (State or Foreign Country): Md.

**9a. FACILITY NAME** (If not institution, give street and number): Bon Secours Hospital

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore City, Md.

**9c. COUNTY OF DEATH**: N/A

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md.

**10b. COUNTY**: N/A

**10c. CITY, TOWN OR LOCATION**: Baltimore, Md.

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 3612 Mac Tavish Ave.-Baltimore, Md.

**10f. ZIP CODE**: 21229

**10g. CITIZEN OF WHAT COUNTRY?**: U. S. A.

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: N/A

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: N/A

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): N/A
College (1-4 or 5+): N/A

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Housewife

**16b. KIND OF BUSINESS/INDUSTRY**: N/A

**17. FATHER'S NAME** (First, Middle, Last): UNKNOWN

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): UNKNOWN

**19a. INFORMANT'S NAME** (Type/Print): Mr. Melvin E. Roloff, Jr.

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 Hunting Creek Ct.-Baltimore, Md. 21228

**20a. METHOD OF DISPOSITION** 4-5-89: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Loudon Park Cemetery

**20c. LOCATION — City or Town, State**: Baltimore, Md.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ G. Truman Schwab

**22. NAME AND ADDRESS OF FACILITY**: 5151 Baltimore National Pike, Baltimore, Md. 21229

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. May be Acute Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
b. Bi pleural effusion with possible
DUE TO (OR AS A CONSEQUENCE OF):
c. Pneumonea.
DUE TO (OR AS A CONSEQUENCE OF):
d. COPD

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☐ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☐ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Sreesh Tripuraneni

**29c. LICENSE NUMBER**: D 30661

**29d. DATE SIGNED** (Month, Day, Year): ▶ 4/2/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): SIREESH TRIPURANENI, Bon Secour Hospital.

**31. DATE FILED** (Month, Day, Year): APR 6 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 11350

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GEORGE RICKETTS | | | | 2. DATE OF DEATH (Month, Day, Year): 4 13 89 | | 3. TIME OF DEATH: 510 AM |
| 4. SOCIAL SECURITY NUMBER: 400 40 2544 | 5. SEX: XX M 2 F | 6. AGE (In yrs. last birthday): 59 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12 22 29 | 8. BIRTHPLACE (State or Foreign Country): Kentucky |
| 9a. FACILITY NAME (If not institution, give street and number): Liberty Medical | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: none | |
| **RESIDENCE OF DECEDENT** | | | | | | |
| 10a. STATE: Md. | 10b. COUNTY: none | | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | |
| 10e. STREET AND NUMBER: 3017 Wolcott Avenue | | | 10f. ZIP CODE: 21216 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 Never Married 2 XX Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer | | 16b. KIND OF BUSINESS/INDUSTRY: Rockland Bleach & Dy | |
| 17. FATHER'S NAME (First, Middle, Last): Thomas Ricketts | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Molly Green | | | |
| 19a. INFORMANT'S NAME (Type/Print): Jerry L. Ricketts | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 622 S. 26th St. Louisville, Ky. 40211 | | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmeadows | | 20c. LOCATION — City or Town, State: Louisville, Ky. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James A. Morton | | | 22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons 1701 Laurens Street 21217 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pneumococcal Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumococcal Bacteremia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Septic Shock | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ER/Outpatient 3 DOA | OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | |
| 27. MANNER OF DEATH: 1 X Natural 2 Accident 3 Suicide 4 Homicide 6 Pending Investigation 6 Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Blake Kutsche MD | D 35788 | ▶ 4-13-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): B. KUTSCHE MD LIBERITY MEDICAL CENTER 2600 LIBERITY HEIGHTS AVE BALTIMORE, MD 21215

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 13 1989 | Davidson Randall |

DHMH-16 Rev 1/89

88 11320

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11351

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARY GRACE RILEY | | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 8, 1989 | 3. TIME OF DEATH: 1245 PM |
| 4. SOCIAL SECURITY NUMBER: 232.42.6177 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 83 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): NOV. 26, 1905 | 8. BIRTHPLACE (State or Foreign Country): WEST VIRGINIA |
| 9a. FACILITY NAME (If not institution, give street and number): BON SECOURS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: CITY |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: CATONSVILLE | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 5743 EDMONSON AVENUE | | 10f. ZIP CODE: 21228 | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 years; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY: OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last): DANIEL BRUCE PAYNE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ALICE MARPLE | |
| 19a. INFORMANT'S NAME (Type/Print): WILLIS RILEY, JR. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8482 BYRD ROAD PASADENA, MD. 21122 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SIMPSON BAPTIST CHURCH CEM. | | 20c. LOCATION — City or Town, State: SIMPSON, W.V. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ | | 22. NAME AND ADDRESS OF FACILITY: SINGLETON FUNERAL HOME GLEN BURNIE, MD. | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute renal failure | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): Sepsis | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): Pneumonia / ecoli - Bacteria | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1) ASCVD
2) NO CPR

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [illegible] M.D. | 12-19528 | ▶ 4/9/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 11 1989 | Gina Davidson-Randall |

OHMH-18 Rev 1/89

88 11321

89 11352

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NANCY. RILEY — NANCY RITA RILEY
2. DATE OF DEATH: MONTH 4 DAY 10 YEAR 89
3. TIME OF DEATH: 2:20 pm M
4. SOCIAL SECURITY NUMBER: 219-38-5827
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12/3/1914
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: ---

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 406 Church Street
10f. ZIP CODE: 21225
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Housewife
17. FATHER'S NAME (First, Middle, Last): Donato DeNisio
18. MOTHER'S NAME (First, Middle, Maiden Surname): Carmella Fusco DeNisio
19a. INFORMANT'S NAME (Type/Print): Mr. William Edward Riley
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 406 Church St., Baltimore, Md. 21225
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Most Holy Redeemer Cemetery
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kevin E. Ecker — K E E
22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Brooklyn, 237 E. Patapsco Ave., Balto., Md. 21225

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Resp Arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Severe Emphysematous Bronchitis

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

S/p amp. amt 2 yr ago
HTN

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Sita Yanamadala
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): 4/10/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SITA. YANAMADALA · Harbor Hosp. Cntr.
31. DATE FILED (Month, Day, Year): APR 11 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMN-18 Rev 1/89

88 11325

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11353
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROOSEVELT REDDICK | | | 2. DATE OF DEATH: MONTH 4 DAY 2 YEAR 89 | 3. TIME OF DEATH: 10 50 A M |
| 4. SOCIAL SECURITY NUMBER: 10-10-5825 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 80 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1/9/09 | 8. BIRTHPLACE (State or Foreign Country): N.C. |
| 9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE CITY |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 3212 Burning Well Rd | | 10f. ZIP CODE: 21207 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Hajoca | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): Unkn | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mamie | |
| 19a. INFORMANT'S NAME (Type/Print): Lester Riddick | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3212 Burning Well Rd Balto.,Md. 21207 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): King Mem. Pk. | 20c. LOCATION — City or Town, State: Randallstown, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Willie Edmond | | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Ave. | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ASYSTOLE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CARDIOMYOPATHY
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Sher A Hashmi | 29c. LICENSE NUMBER: D24648 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-2-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SHER A HASHMI 2600 LIBERTY HEIGHTS AVE BALTIMORE 21215

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 4 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DNMH-16 Rev 1/89

89 1353

x

King Mem. Pk.

Randallstown, Md.

March F\H West
4300 Wabash Ave.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11354
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Willie B. Reynolds
2. DATE OF DEATH: MONTH 4 DAY 10 YEAR 89
3. TIME OF DEATH: 6 21 PM M
4. SOCIAL SECURITY NUMBER: 228429085
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 55 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4/11/33
8. BIRTHPLACE (State or Foreign Country): Va
9a. FACILITY NAME (If not institution, give street and number): HARBOR HOSPITAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD.
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1711 Lamont Avenue
10f. ZIP CODE: 21202
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY: Construction
17. FATHER'S NAME (First, Middle, Last): Willie Reynolds
18. MOTHER'S NAME (First, Middle, Maiden Surname): Nettie Hudson
19a. INFORMANT'S NAME (Type/Print): Rose Reynolds
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1711 Lamont Ave Baltimore Md 21202
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery
20c. LOCATION — City or Town, State: Baltimore Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: March F. H. West 4300 Wabash Ave

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Carcinoma of the pancreas | 2½ month. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF): | Septic | 1½ month. |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Deep vein thrombosis.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
26d. DESCRIBE HOW INJURY OCCURED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] Chief Cardiology c. Dr. MD.
29c. LICENSE NUMBER: [illegible]
29d. DATE SIGNED (Month, Day, Year): 4/10/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR ENG NG
3001 SO. HANOVER STREET • BALT. MD 21230

31. DATE FILED (Month, Day, Year): APR 14 1989
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

89 11355

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be ... hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page ... for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be ...**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): SMITH, BABY BOY (MICHELLE). | | 2. DATE OF DEATH (Month, Day, Year): 4 - 18 - 89 | 3. TIME OF DEATH: 8:03 A M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS —, DAYS 3 — IF UNDER 24 HRS.: HOURS —, MIN. — | 7. DATE OF BIRTH (Month, Day, Year): 4-15-89 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): UNIVERSITY OF M.D. HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: VIRGINIA | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: CHESAPE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2440 WOODSHIRE CIRCLE | | 10f. ZIP CODE: 23323 | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N.A. | 16b. KIND OF BUSINESS/INDUSTRY: N.A. | |
| 17. FATHER'S NAME (First, Middle, Last): ~~ZAZITO~~ CHARLES SMITH | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MICHELLE HIGGINBOTHAM | | |
| 19a. INFORMANT'S NAME (Type/Print): MICHELLE SMITH | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2440 WOODSHIRE CIR, CHESAPE VA 23323 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in-state removal | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CARDIO-RESPIRATORY ARREST | 5 minutes |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | INTRAVENTRICULAR HEMORRHAGE | 36 hours |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | RESPIRATORY DISTRESS SYNDROME | 3 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | PREMATURITY - | 3 days |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE, HYPERKALEMIA.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY M — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Martin J. Kelly MD. | 29c. LICENSE NUMBER: D-34731 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-18-89. |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 23 89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

88 11322

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages [illegible] should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, [illegible] be executed at once.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

### TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): OREN EUGENE SNYDER
2. DATE OF DEATH (Month, Day, Year): MAY 8, 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 163-14-4841
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): April 23,1919
8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): FRANCIS SCOTT KEY MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: DUNDALK
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2501 AMBLER ROAD
10f. ZIP CODE: 21222
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WWII ARMY
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Not Known — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Equipment Operator
16b. KIND OF BUSINESS/INDUSTRY: Wilson Company
17. FATHER'S NAME (First, Middle, Last): Wilbert Snyder
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lottie Not known
19a. INFORMANT'S NAME (Type/Print): Laura Fritze
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3703 Red Berry Way, Baltimore, MD 21236
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Paul's Lutheran 5/12/89
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John F. Collins
22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MD 21222

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES [X] NO — INQUIRY
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
26a. DATE OF INJURY (Month, Day, Year):
26b. TIME OF INJURY: M
26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
26d. DESCRIBE HOW INJURY OCCURED:
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ 5-9-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P.Kokes,M.D. 111 Penn Street,Baltimore,MD 21201 VC
31. DATE FILED (Month, Day, Year): MAY 12 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Henry W. Slee | | | | | 2. DATE OF DEATH (Month, Day, Year): 4 15 89 | | | 3. TIME OF DEATH: 12:30 PM |
| 4. SOCIAL SECURITY NUMBER: 212-07-4456 | 5. SEX: 1 M 2 F | 6. AGE (In yrs. last birthday): 75 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3/16/14 | | | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Keswick Home For The Incurables | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | | 9c. COUNTY OF DEATH: — |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md | | BALTIMORE | 1 X YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 700 W 40th St. | 21211 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ■ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ■ NO | 1 ☐ YES 2 ☐ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | | | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Joseph P. Slee | Mary E Matthiesen |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MRS. JAMES SHELBY | 214 Chadsworth Ave., Reisterstown, Md. 21236 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ■ Donation 5 ☐ Other (Specify) Anatomy Board | | |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ [signature] | STATE ANATOMY BOARD, BALTO., MD. 21201 |

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. COPD | YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CEREBRAL PALSY | YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

**29a. CERTIFIER** (Check only one)

1 X **CERTIFYING PHYSICIAN:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **MEDICAL EXAMINER:** On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| John F. Hartman, MD | D0-5403 | ▶ 4-15-1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

JOHN F HARTMAN, M.D. KESWICK - 700 W. 40th St. Balto. Md 21211

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 0 9 1989 | Julia Davidson-Randall |

89 11358

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Shearin
2. DATE OF DEATH (Month, Day, Year): 4 / 14 / 89
3. TIME OF DEATH: 2 54 P M
4. SOCIAL SECURITY NUMBER: 239-20-4277
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1-16-21
8. BIRTHPLACE (State or Foreign Country): LITTLETON, N.C.
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 5200 EASTERN AVE.
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY?: U.S.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): HAYWOOD SHEARIN
18. MOTHER'S NAME (First, Middle, Maiden Surname): PEARL WILLIAMS
19a. INFORMANT'S NAME (Type/Print)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) in-state removal
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE
22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. pneumonia — Approximate Interval Between Onset and Death: 3 weeks

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

renal failure

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Clifford S Mitchell MD Junior Assistant Resident
29c. LICENSE NUMBER: D37382
29d. DATE SIGNED (Month, Day, Year): 4/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ANNE M. STOLINE, MD
31. DATE FILED (Month, Day, Year): MAY 10 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Rhodes

DHMH-16 Rev 1/89

88 11328

89 11359

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): SAMUEL Rice SPENCER

**2. DATE OF DEATH** Month: 4 Day: 28 Year: 89

**3. TIME OF DEATH**: 10:48 P.M.

**4. SOCIAL SECURITY NUMBER**: 230-28-4974

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 61 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 10-20-27

**8. BIRTHPLACE** (State or Foreign Country): Va.

**9a. FACILITY NAME** (If not institution, give street and number): HOMEWOOD HOSPITAL CENTER

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore City

**9c. COUNTY OF DEATH**: Baltimore County

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: BALTIMORE

**10d. INSIDE CITY LIMITS?** 1 [X] YES 2 [ ] NO

**10e. STREET AND NUMBER**: 2348 EUTAW PLACE

**10f. ZIP CODE**: 21217

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: BLACK

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): LABORER

**16b. KIND OF BUSINESS/INDUSTRY**: NA

**17. FATHER'S NAME** (First, Middle, Last): SAMUEL SPENCER

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): GRACIE SNEAD

**19a. INFORMANT'S NAME** (Type/Print): JEFFRESS FUNERAL HOME

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): CHARLOTTE COURT HOUSE, CHARLOTTE, VA 23923

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): ST. LOUIS BAPT. CHURCH CEM.

**20c. LOCATION — City or Town, State**: CHARLOTTE, VA

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Gladys Warren

**22. NAME AND ADDRESS OF FACILITY**: WM. C. MARCH F/H 1101 E. NORTH AVENUE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Respinatory Distress syndrome
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Extensive Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [X] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [X] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Marcos Galicia M.D

**29c. LICENSE NUMBER**: D15698

**29d. DATE SIGNED** (Month, Day, Year): ▶ 4/28/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): MARCOS GALICIA M.D.

**31. DATE FILED** (Month, Day, Year): MAY 1 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

OHMH-16 Rev 1/89

65211 68

89 11360

1 - FOR STATE REGISTRAR Anna Spooner

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Anna n/M/N SPOONER | | | 2. DATE OF DEATH: MONTH March DAY 17, YEAR 89 | 3. TIME OF DEATH: 09:41 A M |
| 4. SOCIAL SECURITY NUMBER: 236-03-8109 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 7-21-1913 | 8. BIRTHPLACE (State or Foreign Country): POLAND |
| 9a. FACILITY NAME (If not institution, give street and number): Physicians Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: LaPLata | | 9c. COUNTY OF DEATH: Charles |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: CHARLES | 10c. CITY, TOWN OR LOCATION: WHITE PLAINS | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Rt. 1, Box 365A | | 10f. ZIP CODE: 20695 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+): -- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): Louis Duda | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Czgnai | |
| 19a. INFORMANT'S NAME (Type/Print): Dorothy Gregan | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1, Box 365A, White Plains, Md. 20695 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): East Oaek Grove Cemetery | 20c. LOCATION — City or Town, State: Morgantown, West Virginia |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: Huntt Funeral Home, P. O. Box 156, Waldorf, Md. 20604-0156 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Diabetic Wet Ketotic Hyperosmolar Coma DUE TO (OR AS A CONSEQUENCE OF): | 1 day |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: — possible acute MI

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: D0295 | 29d. DATE SIGNED (Month, Day, Year): ▶ 3-17-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Daniel Howell Pembrook Square #104 Waldorf, MD. 20601

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAR 21 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 11350

1 · FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89-11361

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Charles | William | Stettes Jr. | 4-26-89 | 11:20AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-36-0916 | 1 ☒ M 2 ☐ F | 49 YRS. | | | 9-5-39 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 5509 Hilltop Avenue | Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | | Baltimore City | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 5509 Hilltop Avenue | 21206 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12th grade | | Policeman | Baltimore City Police Dept. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Charles William Stettes,Sr. | Martha C. Trabert |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Alverta M. Stettes | 5509 Hilltop Avenue Balto., Md. 21206 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Gardens of Faith Cemetery | Baltimore, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Lassahn Funeral Home | 7401 Belair Rd. Baltimore, Maryland 21236 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cohtact gunshot wounds to head and abdomen
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| ☒ YES 2 ☐ NO | 1 ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) |
|---|---|
| ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 4-26-89 | M | 1 ☐ YES 2 ☒ NO | self inflicted |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| home | 5509 Hilltop Avenue |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Margarita A. Korell | ocme | ▶ 4-27-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Margarita A. Korell,M.D. 111 Penn Street,Baltimore,MD 21201 vc

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 1 1989 | Linda Davidson-Randall |

30

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11362
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROBERT D. SCHMIDT | | | 2. DATE OF DEATH (Month, Day, Year): 4 28 89 | 3. TIME OF DEATH: 9-20 A M |
| 4. SOCIAL SECURITY NUMBER: 218-03-2076 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7-26-1920 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Bon Secours | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4703 Aldgate Green | | 10f. ZIP CODE: 21227 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WW2 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Oil greaser | | 16b. KIND OF BUSINESS/INDUSTRY: Manufacturing |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Schmidt | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Spindler | | |
| 19a. INFORMANT'S NAME (Type/Print): Eleanor L. Schmidt | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4703 Allgate Green Baltimore, Md. 21227 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Cemetery | | 20c. LOCATION — City or Town, State: Dorsey, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road 21227 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cerebro Vascular Accident | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. ATHERSCLEROSIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. Diabetes Mellitus | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: congestive heart failure Peripheral Vascular disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | | | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD Physician | D 21649 | ▶ 4-28-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SANDAM BASKARAN MD. 2455 Wilkens Ave Baltimore MD 21223

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 1 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 11363

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be completed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RUTH SATTIZAHN | | | 2. DATE OF DEATH: MONTH 04 DAY 29 YEAR 1989 | 3. TIME OF DEATH: 1:50 AM M |
| 4. SOCIAL SECURITY NUMBER: 192-30-6738 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 50 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 1-8-39 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: ~~BALTIMORE~~ |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: ========== | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 120 S. Washington Street | | 10f. ZIP CODE: 21231 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): (unknown) | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): (unknown) | |
| 19a. INFORMANT'S NAME (Type/Print): Dale Kevin Sattizahn | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 120 S. Washington Street Baltimore, Md. 21231 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Westview Memorial Park | 20c. LOCATION — City or Town, State: Westview, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jerome Framiewski | | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | perforated colon | 1 month |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | colon carcinoma stage D | unknown |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: diabetes

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D36943 | 29d. DATE SIGNED (Month, Day, Year): 4/29/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Henry DeGroot MD 600 N. Wolfe St Baltimore MD 21205

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 3 1989 | 32. REGISTRAR'S SIGNATURE: Juba Davidson-Randall |

DHMH-16 Rev 1/89

88 11383

89 11364

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WARREN SMITH | | 2. DATE OF DEATH (Month, Day, Year): 4 29 89 | 3. TIME OF DEATH: 1-40 pm |
| 4. SOCIAL SECURITY NUMBER: 213-16-3399 | 5. SEX: ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 79 yrs. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 02/09/10 |
| 8. BIRTHPLACE (State or Foreign Country): MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 5410 Denmore ~~Road~~ Ave | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 — 4; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): GARAGEMAN | 16b. KIND OF BUSINESS/INDUSTRY: RAILWAY EXPRESS | |
| 17. FATHER'S NAME (First, Middle, Last): WARREN SMITH | 18. MOTHER'S NAME (First, Middle, Maiden Surname): JULIA GOINES | | |
| 19a. INFORMANT'S NAME (Type/Print): MR. ELBERT ROWLAND | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5410 DENMORE AVENUE BALTIMORE, MARYLAND 21215 | | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): EASTVIEW MEMORIAL PARK 5/6/89 | 20c. LOCATION — City or Town, State: BALTO., MD. 21224 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lewis T Gwynn | 22. NAME AND ADDRESS OF FACILITY: LEWIS T. GWYNN FUNERAL HOME 21215 - 6393 4517 PARK HEIGHTS AVENUE BALTIMORE, MARYLAND | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Chronic Atrial Fibrillation | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | |
|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Attending House officer SINAI Hospital (2451) | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/29/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): K.P Bhadha, Sinai Hospital HP, Baltimore, MD. | | |
| 31. DATE FILED (Month, Day, Year): MAY 1 - 1989 | 32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall | |

DHMH-16 Rev 1/89

89 1136

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11365

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Grace Smith | | | 2. DATE OF DEATH (Month, Day, Year): April 6, 1989 | 3. TIME OF DEATH: 8:50A M |
| 4. SOCIAL SECURITY NUMBER: 055-07-9223 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 05-07-14 | 8. BIRTHPLACE (State or Foreign Country): BALTO., MD. |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: BALTIMORE CITY | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE CITY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1100 PENNSYLVANIA AVE. APT. 601 | | 10f. ZIP CODE: 21201 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5 +) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RETIRED | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): JOHN HAMPTON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY E. JACKSON | |
| 19a. INFORMANT'S NAME (Type/Print): DOROTHY A. NELSON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1100 BOLTON STREET APT. 215 (21201) | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PK. | 20c. LOCATION — City or Town, State: BALTO., MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lynette K. Jones | | 22. NAME AND ADDRESS OF FACILITY: BROWN-THOMPSON F.H. P.O. BOX 4433 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Septic Shock | |
| | DUE TO (OR AS A CONSEQUENCE OF): Pneumonia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): Chronic obstructive pulmonary disease | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Massive cerebrovascular disease; Gastro intestinal bleeding; Hypertension; Renal failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: IAN TANG M.D. | 29c. LICENSE NUMBER: N/A | 29d. DATE SIGNED (Month, Day, Year): 4/6/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ian Tsai-leu Tang, M.D. c/o Maryland General Hospital

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 11 1989 | 32. REGISTRAR'S SIGNATURE: Lida Davidson-Randall |

DHMH-16 Rev 1/89

88 11302

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EVELYN P. STOKES | | 2. DATE OF DEATH: MONTH 04 DAY 17 YEAR 89 | 3. TIME OF DEATH: 3:40 PM |
| 4. SOCIAL SECURITY NUMBER: 578-84-3501 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10/25/06 |
| 8. BIRTHPLACE (State or Foreign Country): WASHINGTON, DC | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Pleasant Living Conv. Ctr | 9b. CITY, TOWN OR LOCATION OF DEATH: Edgewater | 9c. COUNTY OF DEATH: A. A. | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: EDGEWATER | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3568 LOCH HAVEN DRIVE | | 10f. ZIP CODE: 21037 | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last): H. LEON PHILLIPS | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET CADY | |
| 19a. INFORMANT'S NAME (Type/Print): MAXWELL STOKES, JR. SON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3568 LOCH HAVEN DRIVE EDGEWATER, MD 21037 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY | 20c. LOCATION — City or Town, State: SILVER SPRING, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael L Byler | | 22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIV BLVD W SILVER SPRING, MD 20901 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Alzheimer's disease ~~FOUNDATION~~ INVASION | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus, Arthritis Hypertension, Atherosclerosis

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Peter F. Verkouw | 29c. LICENSE NUMBER: D11653 | 29d. DATE SIGNED (Month, Day, Year): 4/17/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PETER F. VERKOUW, 1833 Forest Drive, Annapolis | | |
| 31. DATE FILED (Month, Day, Year): APR 20 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson Randall | Md 21401 |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

15

89 11367

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DAVID STELLER | | | 2. DATE OF DEATH (Month, Day, Year): 04 25 89 | 3. TIME OF DEATH: 2-15 PM |
| 4. SOCIAL SECURITY NUMBER: 436-20-1279 | 5. SEX: 1 M 2 F | 6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8.23.15 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, MD. | | 9c. COUNTY OF DEATH: Baltimore City |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore City | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| 10e. STREET AND NUMBER: 3313 Poplar Street | 10f. ZIP CODE: 2126 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Jockey | 16b. KIND OF BUSINESS/INDUSTRY: Horse Racing | |
| 17. FATHER'S NAME (First Middle, Last): David Raymond Stuller | 18. MOTHER'S NAME (First, Middle, Maiden Surname): H. Grace Eckard | | |
| 19a. INFORMANT'S NAME (Type/Print): Melba Swick | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27 E. Main St. Apt. 4 Westminster Md. 21157 | | |
| 20a. METHOD OF DISPOSITION: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Carroll Creation Services | 20c. LOCATION — City or Town, State: Hampstead Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas V. Fletcher | 22. NAME AND ADDRESS OF FACILITY: Fletcher Funeral Home Westminster Md. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory failure with

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Chronic obstructive lung diseases

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

malnutrition.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA | OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: R.M. Shah M.D | 29c. LICENSE NUMBER: D19668 | 29d. DATE SIGNED (Month, Day, Year): R.M. SHAH M.D |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R.M. SHAH, LIBERTY Medical Center, 2500 LIBERTY HT AVE. Baltimore MD | | |
| 31. DATE FILED (Month, Day, Year): MAY 1 '89 | 32. REGISTRAR'S SIGNATURE: | |

DHMH-18 Rev 1/89

89 11368

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARTHA J. SMITH | | 2. DATE OF DEATH (Month, Day, Year): APRIL 26, 1989 | 3. TIME OF DEATH: 10:30 A M |
| 4. SOCIAL SECURITY NUMBER: 577-50-7679 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): June 14, 1937 |
| 8. BIRTHPLACE (State or Foreign Country): Wash.D.C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: ~~BALTIMORE~~ | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Charles | 10c. CITY, TOWN OR LOCATION: White Plains | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: Route 1 Box 134 | 10f. ZIP CODE: 20695 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 1/12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Management Analyst | 16b. KIND OF BUSINESS/INDUSTRY: US Postal Service | |
| 17. FATHER'S NAME (First, Middle, Last): Albert J. Fortin | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eva Goulet | | |
| 19a. INFORMANT'S NAME (Type/Print): Blair Smith | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 1 Box 134 White Plains, Md. 20695 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): George Washington Cemetery | 20c. LOCATION — City or Town, State: Adelphi, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael Ornella | 22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home 11800 New Hamp.Ave.S.S.Md. | | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Transtentorial Pressure Syndrome | 12 HRS |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Raised Intracranial Pressure | 10 days |
| | DUE TO (OR AS A CONSEQUENCE OF): c. Cerebral Oedema | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. Left frontal Glioblastoma Multiforme | 4 months |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): N/A; 28b. TIME OF INJURY: M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURRED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: DR H Donnelly Resident MD Neurosurgery | 29c. LICENSE NUMBER: JHH C9433 | 29d. DATE SIGNED (Month, Day, Year): 4.26.89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR HDT O'DONNELL JOHNS HOPKINS HOSPITAL Meyer 7-109 Baltimore MD 21204 | | |
| 31. DATE FILED (Month, Day, Year): APR 28 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

12

89 11369

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EDWARD E. SAMPSON | | | 2. DATE OF DEATH (Month / Day / Year): 04 / 09 / 89 | 3. TIME OF DEATH: 6:45 P M |
| 4. SOCIAL SECURITY NUMBER: 218-05-4552 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 70 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 11 5 18 | 8. BIRTHPLACE (State or Foreign Country): MD. |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore city | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD. | 10b. COUNTY: Glen Burnie | 10c. CITY, TOWN OR LOCATION: | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO |
| 10e. STREET AND NUMBER: 6666 Robert ct | | 10f. ZIP CODE: 21016 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: B |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Male Nurse | | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): Morris SAMPSON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET | | |
| 19a. INFORMANT'S NAME (Type/Print): Lillie Mae Thompson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 124 W. Franklin St Balto., MD. 21201 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Westview Crematory | | 20c. LOCATION — City or Town, State: Balto., MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ WMC Brown | | 22. NAME AND ADDRESS OF FACILITY: WM C. BROWN COMM. F.H. 1206 W. North Ave | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARDIO-RESPIRATORY ARREST

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. MASSIVE UPPER GI BLEEDING

DUE TO (OR AS A CONSEQUENCE OF):
c. HEPATIC DYSFUNCTION

DUE TO (OR AS A CONSEQUENCE OF):
d. SEVERE ALCOHOLIC LIVER CIRRHOSIS

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
COPD
SCROTAL CELLULITIS
ANEMIA & THROMBOCYTOPENIA

24a. WAS AN AUTOPSY PERFORMED? 1 ☑ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO N/A

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): NA
28b. TIME OF INJURY: NA M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO NA
28d. DESCRIBE HOW INJURY OCCURED: NA
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): NA
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): NA

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Griselda E. Tiu MD - MED. INTERN | | ▶ 04-09-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GRISELDA E. TIU MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 24 1989 | Julia Davidson-Rodriguez |

DHMH-18 Rev 1/89

89 11370

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MAMIE SANDERS | | | | 2. DATE OF DEATH (Month, Day, Year): 4 25 89 | 3. TIME OF DEATH: 10 10 P M |
| 4. SOCIAL SECURITY NUMBER: 218789496 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 81 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9/28/07 | 8. BIRTHPLACE (State or Foreign Country): AL |
| 9a. FACILITY NAME (If not institution, give street and number): GOOD SAMARITAN HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: [redacted] |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | | BALTIMORE | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1527 WINDEMERE AVENUE | 21218 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+): 1 YR | HOUSEWIFE | DOMESTIC |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| WARREN BROWN | MARELLA JONES |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JAMES SANDERS | 1527 WINDEMERE AVE. /BALTIMORE, MD 21218 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | EASTVIEW MEMORIAL APRK | DUNDALK, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ [signature] | WM. C. MARCH F/H 1101 E. NORTH AVENUE |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac-Respiratory Arrest. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Bronchoalveolar Ca. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Postobstructive pneumonitis. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] Intern | D38118 | ▶ 4/25/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
XENOPOULOS P. NICHOLAS 5601 Loch Raven Blvd Balt. MD 21239

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 28 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 11371

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Catherine Albertha Schlogel
2. DATE OF DEATH (Month, Day, Year): 04 11 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 212-09-3756
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 01 10 20
8. BIRTHPLACE (State or Foreign Country): Md.

9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: City

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Dundalk
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1748 Burnham Road
10f. ZIP CODE: 21222
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housework
16b. KIND OF BUSINESS/INDUSTRY: At Home
17. FATHER'S NAME (First, Middle, Last): John Oliver Goodwin
18. MOTHER'S NAME (First, Middle, Maiden Surname): Theresa Rose Herbert
19a. INFORMANT'S NAME (Type/Print): Catherine T. Bocklage
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1748 Burnham Road Dundalk, Md. 21222
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Memorial Gardens
20c. LOCATION — City or Town, State: Middle River, Balto. Co.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles D Zeiler
22. NAME AND ADDRESS OF FACILITY: Charles S. Zeiler & Son Inc. 6224 Eastern Av.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrest
DUE TO (OR AS A CONSEQUENCE OF): b. Ca of Colon - S/P Resection
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF): c. Mitral Stenosis
DUE TO (OR AS A CONSEQUENCE OF): d. Atrial Fibrillation

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Michael F Statt
29c. LICENSE NUMBER: DO 9646
29d. DATE SIGNED (Month, Day, Year): ▶ 4/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): APR 18 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 11372

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Virginia P. Schmidt | | | 2. DATE OF DEATH (Month, Day, Year): 4-19-89 | 3. TIME OF DEATH: 7:30PM M |
| 4. SOCIAL SECURITY NUMBER: 219-58-4879 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 32 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2-12-57 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): 1624 E. Clement Street | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Md. | 10b. COUNTY: - | 10c. CITY, TOWN OR LOCATION: Balto. City | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1624 E. Clement St. | | 10f. ZIP CODE: 21230 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Office Worker | | 16b. KIND OF BUSINESS/INDUSTRY: Crusader Chemical Co. |
| 17. FATHER'S NAME (First, Middle, Last): Henry R. Schmidt | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Huber | | |
| 19a. INFORMANT'S NAME (Type/Print): Margaret V. Schmidt | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3827 Lyndale Ave. Balto., Md. 21213 | | |
| 20a. METNOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Cemetery | | 20c. LOCATION — City or Town, State: Balto., Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: John C. Miller Inc. 6415 Belair Rd. Balto., Md. 21206 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Seizure disorder and fatty liver
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Chronic alcoholism
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| ☒ YES 2 ☐ NO | ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | OCME | ▶ 4-20-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn Street, Baltimore, MD 21201

VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 21 1989 | [signature] |

DNMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 11373

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Anna D. Schutz | | | 2. DATE OF DEATH (Month, Day, Year): 4-17-89 | 3. TIME OF DEATH: 6:40PM M |
| 4. SOCIAL SECURITY NUMBER: 218-74-1288 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Oct. 19, 1901 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): 3403 Shannon Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md. | 10b. COUNTY: – | 10c. CITY, TOWN OR LOCATION: Balto. City | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3403 Shannon Dr. Balto., Md. | | 10f. ZIP CODE: 21213 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 / College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): Charles Hager | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Blanche Born | | |
| 19a. INFORMANT'S NAME (Type/Print): Gloria B. D'Arciprete | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3566 Elmora Ave. Balto., Md. 21213 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cem. | | 20c. LOCATION — City or Town, State: Balto., Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Thomas J. Miller | | 22. NAME AND ADDRESS OF FACILITY: John C. Miller Inc. 6415 Belair Rd. Balto., Md. 21206 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |
| INSPECTION | |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: ☒ 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Charles P. Kokes MD | OCME | ▶ 4-18-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
VC Charles P. KOkes, M.D. 111 Penn Street, Baltimore, MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 21 1989 | Julia Davidson-Landers |

DHMH-16 Rev 1/89

89 11373

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11374
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Robert Shackelford | | | 2. DATE OF DEATH (Month, Day, Year): 4 18 1989 | 3. TIME OF DEATH: 1:03 PM |
| 4. SOCIAL SECURITY NUMBER: 224 07 5020 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 70 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): Nov 6, 1918 | 8. BIRTHPLACE (State or Foreign Country): VIRGINIA |
| 9a. FACILITY NAME (If not institution, give street and number): HOMEWOOD HOSPITAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: HARFORD | 10c. CITY, TOWN OR LOCATION: ABERDEEN | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 429 RUBY DR. | | 10f. ZIP CODE: 21001 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) |
| | | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): EDWIN T. SHACKELFORD | 18. MOTHER'S NAME (First, Middle, Maiden Surname): WILLIE L. JONES |
| 19a. INFORMANT'S NAME (Type/Print): TRUDY SHACKELFORD | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1007 Warwick Dr., Aberdeen, Md. 21001 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald McKee | 22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis | 1 week |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Neutropenia | 1 week |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Oat cell Lung cancer | 4 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia, Urinary tract infection
Chronic Obstructive Pulmonary Disease
Coronary artery Disease; Tobacco

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: D Boersma MD (Medical Resident) | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/18/1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): D. BOERSMA, MD Homewood Hospital Center, Balto. MD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 25 1989 | 32. REGISTRAR'S SIGNATURE: [signature] |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89-11375

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 ... by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 ... be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Daniel H Shear
2. DATE OF DEATH: MONTH 4 DAY 18 YEAR 89
3. TIME OF DEATH: 11:35 PM
4. SOCIAL SECURITY NUMBER: 214-26-2516
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 60 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4/27/28
8. BIRTHPLACE (State or Foreign Country): Baltimore, MD

9a. FACILITY NAME (If not institution, give street and number): Univ of MD Hospital Cancer Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore City

**RESIDENCE OF DECEDENT**

10a. STATE: MD
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Chevy Chase
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4701 Willard Ave A1213
10f. ZIP CODE: 20815
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+): 8
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Attorney
16b. KIND OF BUSINESS/INDUSTRY: Govt./Self-employed

17. FATHER'S NAME (First, Middle, Last): Hyman Shear
16. MOTHER'S NAME (First, Middle, Maiden Surname): Fannie N Milzman

19a. INFORMANT'S NAME (Type/Print): Natalie Shear (Wife)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same address as #10

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Judean Memorial Gardens
20c. LOCATION — City or Town, State: Olney, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶
22. NAME AND ADDRESS OF FACILITY: Ives-PEarson Funeral Homes Falls Church, Va. 22046

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. DO not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Metastatic Colon Carcinoma — 7 months
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Lawrence Rush MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year) ▶ 4/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Lawrence Rush MD, University of Maryland Hospital
31. DATE FILED (Month, Day, Year): APR 20 1989
32. REGISTRAR'S SIGNATURE: Julia Kaufman

OHMH-16 Rev 1/89

89 11376

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HATTIE M. SHORT | | | | 2. DATE OF DEATH (Month, Day, Year): 4/19/89 | 3. TIME OF DEATH: 7:00 P M |
| 4. SOCIAL SECURITY NUMBER: 402-01-5898 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 71 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH: March 24, 1918 | 8. BIRTHPLACE (State or Foreign Country): Kentucky |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: ----- |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Dundalk | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO |
| 10e. STREET AND NUMBER: 8038 Wallace Road | | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dog Breeder | 16b. KIND OF BUSINESS/INDUSTRY: Self Employed | |
| 17. FATHER'S NAME (First, Middle, Last): Clarence S. Osborne | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lettie Bentley | |
| 19a. INFORMANT'S NAME (Type/Print): Lawrence Short | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8038 Wallace Road, Baltimore, MD 21222 | | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Memorial Park 4/25/89 | 20c. LOCATION — City or Town, State: Lexington, KY | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gregory E. Ruck | 22. NAME AND ADDRESS OF FACILITY: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Baltimore, MD 21222 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ischemic Cardiomyopathy

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Thom P Schlueter MD | 29c. LICENSE NUMBER: D37208 | 29d. DATE SIGNED (Month, Day, Year): 4/19/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11377
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ESTELLE G. SINSHEIMER | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 18, 1989 | 3. TIME OF DEATH: 5 AM M |
| 4. SOCIAL SECURITY NUMBER: 218-32-0697 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 96 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): SEPT. 1, 1892 |
| 8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA | | | | |

9a. FACILITY NAME (If not institution, give street and number): APT. 805 PARK TOWERS EAST-7111 PARK HEIGHTS AVE.
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 7111 PARK HEIGHTS AVE. APT. 805 | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: AT HOME |
| 17. FATHER'S NAME (First, Middle, Last): JOSEPH GERSTLEY | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): IDA FREITAG | |
| 19a. INFORMANT'S NAME (Type/Print): LOUIS A. SINSHEIMER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7905 IVY LA. BALTO., MD 21208 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE HEBREW | 20c. LOCATION — City or Town, State: BALTIMORE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Sydney L. Stellman | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215) | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, DF complicationa that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, DF heart failura. List only one cause DN each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CARDIO-PULMONARY ARREST | |
| DUE TO (OR AS A CONSEQUENCE OF): b. | ARTERIOSCLEROTIC CARDIOVASCULAR DISASE | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | — | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | — | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERY DISEASE
CONGESTIVE HEART FAILURE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Howard B. Glenn M.D. | 29c. LICENSE NUMBER: D-21680 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/18/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] 6717 PARK HEIGHTS AVE. 21215 | | | |
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall | | |

OHMH-16 Rev 1/89

89 11378

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): William O. Smiley | | | 2. DATE OF DEATH (Month, Day, Year): April 14 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 705-05-9353 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Aprilll 1904 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Villa St.Michael Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH: BAltimore | | 9c. COUNTY OF DEATH: Baltimore City |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Essex | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 202 S. Marlyn Ave. | | 10f. ZIP CODE: 21221 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY: RailRoad | |
| 17. FATHER'S NAME (First, Middle, Last): ==== ===== | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ===== ====== | | |
| 19a. INFORMANT'S NAME (Type/Print): Janet Stapf | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8105CandleLane BAlto. Md. 21237 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Cemetery | 20c. LOCATION — City or Town, State: MiddleRiver Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Connelly Funeral Home | 22. NAME AND ADDRESS OF FACILITY: ConnellyFuneralHome 300MAceAve.2122 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cancer Rectum
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. with metastase
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 5 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 5 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D15872 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-19-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | 32. REGISTRAR'S SIGNATURE: [signature] |

DHMH-18 Rev 1/89

89 11378

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 11379

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): N. ROBERT SPENCER | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 16 1989 | 3. TIME OF DEATH: 10 P. M |
| 4. SOCIAL SECURITY NUMBER: 217-33-3666 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 48 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 11-13-1940 | 8. BIRTHPLACE (State or Foreign Country): Penna. |
| 9a. FACILITY NAME (If not institution, give street and number): UNION MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH: --- | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2822 Mayfield Avenue | | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4 or 5+): - | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Launch Operator | 16b. KIND OF BUSINESS/INDUSTRY: Ship Yard | |
| 17. FATHER'S NAME (First, Middle, Last): Norman Andrew Spencer | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary E. Clark | |
| 19a. INFORMANT'S NAME (Type/Print): Elizabeth Spencer | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2822 Mayfield Avenue, Baltimore, Md. 21213 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery | 20c. LOCATION — City or Town, State: Balto., Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John F. Schimunek | | 22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Baltimore Md. 21213 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. MYOCARDIAL INFARCTION, ACUTE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [✓] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [✓] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [✓] Other (Specify) HOSPITAL | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [✓] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: D23967 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/17/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. CESAR GAMBOA 3440 BELAIR RD., BALTIMORE, MD. 21213

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | 32. REGISTRAR'S SIGNATURE: [signature] Gordon Randall |

DHMH-18 Rev 1/89

Items23a thu28d FilmG651 CG
5/1/89 per M.E.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11380
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Edward B. Spicer | | | 2. DATE OF DEATH (Month, Day, Year): 4-2-89 | | 3. TIME OF DEATH: 5:59PM M |
| 4. SOCIAL SECURITY NUMBER: 217 72 5969 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 25 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): December 30'63 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: Baltimore City | | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Pasadena | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO |
| 10e. STREET AND NUMBER: 7744 Glen Ave. | 10f. ZIP CODE: 21122 | 10g. CITIZEN OF WHAT COUNTRY?: United States | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction/ Intaller | 16b. KIND OF BUSINESS/INDUSTRY: Fire Sprinklers | |
| 17. FATHER'S NAME (First, Middle, Last): Harry E. Spicer, Sr. | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Thelma B. Hutson | | |
| 19a. INFORMANT'S NAME (Type/Print): Harry E. Spicer, Sr. | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7744 Glen Ave. Pasadena, MD 21122 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | 20c. LOCATION — City or Town, State: Glen Bunrie, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Stella D. Simmons | 22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Pasadena 3204 Mountain Rd., Pasadena, MD 21122 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac arrhythmia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Hypertrophic cardiomyopathy | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XX YES 2 ☐ NO | XX YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XX YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 XX ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 XX Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Charles P. Kokes MD | OCME | ▶ 4-3-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn Street, Baltimore, MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 6 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

68 11380

Item #6 per F.H. 5/31/89 cg

89 11381

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Richard Smith | | | 2. DATE OF DEATH (Month / Day / Year): 04 / 11 / 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 218-05-9562 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): ~~89~~ 99 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 03-14-1890 | 8. BIRTHPLACE (State or Foreign Country): BALTO., MD. |
| 9a. FACILITY NAME (If not institution, give street and number): 512 MOUNT HOLLY STREET | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: BALTIMORE CITY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE CITY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 512 Mt. Holly st. | | 10f. ZIP CODE: 21229 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RETIRED | 16b. KIND OF BUSINESS/INDUSTRY: LONGSHOREMAN |
| 17. FATHER'S NAME (First, Middle, Last): ? BATTLE | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH SMITH | |
| 19a. INFORMANT'S NAME (Type/Print): RICHARD SMITH JR. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 512 MOUNT HOLLY STREET (21229) | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Annette K. Jones | | 22. NAME AND ADDRESS OF FACILITY: BROWN-THOMPSON F.H. P.O. BOX 4433 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, Dr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, Dr heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiovascular Disease.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Hx CHF

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Probable GI malignancy

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO |

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: CD Koenig MD | 29c. LICENSE NUMBER: D27860 | 29d. DATE SIGNED (Month, Day, Year): 4/12/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Alice Aldrich PA-C WUMC 700 Washington Blvd, Balto MD 21230

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 13 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

88 11381

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11382
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOHN GORDON STAYLOR | | | 2. DATE OF DEATH (Month, Day, Year): 4 / 26 / 89 | 3. TIME OF DEATH: 9:46A.M. M |
| 4. SOCIAL SECURITY NUMBER: 212-07-2908 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11/10/15 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATN |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Arbutus | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 5217 Arbutus Avenue | | 10f. ZIP CODE: 21227 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+): | | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Investigator | | 16b. KIND OF BUSINESS/INDUSTRY: Transit & Traffic |
| 17. FATHER'S NAME (First, Middle, Last): John P. Staylor | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Zola Smith | | |
| 19a. INFORMANT'S NAME (Type/Print): Catherine A. Staylor | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5217 Arbutus Avenue Baltimore, Md. 21227 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jackie D. Shannon | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Bronchopneumonia, confluent, lower lobes, with abscess
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atherosclerosis, generalized, severe, insulin dependent diabetes mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): N/A | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Michael E Pelczar MD | 29c. LICENSE NUMBER: D09990 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/26/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael E. Pelczar, M.D.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 28 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

ONMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11383
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ARTHUR M. STEVENSON | | 2. DATE OF DEATH (Month, Day, Year): 4/17/89 | 3. TIME OF DEATH: 0615 AM |
| 4. SOCIAL SECURITY NUMBER: 213-03-8497 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): JAN. 3, 1918 |
| 8. BIRTHPLACE (State or Foreign Country): MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH: -- | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: ARBUTUS | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 900 CIRCLE DRIVE | | 10f. ZIP CODE: 21227 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BROKER | 16b. KIND OF BUSINESS/INDUSTRY: REAL ESTATE |
| 17. FATHER'S NAME (First, Middle, Last): ARTHUR M. STEVENSON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): NELLIE PUMPHREY | |
| 19a. INFORMANT'S NAME (Type/Print): EVELYN STEVENSON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 900 CIRCLE DRIVE, ARBUTUS, MARYLAND 21227 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTVIEW CREMATORY | 20c. LOCATION — City or Town, State: CATONSVILLE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kenneth Witzke | | 22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES, 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Ca. Esophagus. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: E Cluma, Resident Physician | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/17/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E. CLUMA, ST. AGNES HOSPITAL, BALTIMORE, MARYLAND

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 24 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

88 11383

89 11384

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): KATHERINE G. STEVENS | | | | | 2. DATE OF DEATH (Month, Day, Year): 04 18 89 | 3. TIME OF DEATH: 11:47A M |
| 4. SOCIAL SECURITY NUMBER: 217-09-0648 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 71 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Mar. 2/1918 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Balto. City, Md. | | 9c. COUNTY OF DEATH: ------- | |
| **RESIDENCE OF DECEDENT** | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: A.ACo. | 10c. CITY, TOWN OR LOCATION: Pasadena | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 123 Cecil Rd. | | 10f. ZIP CODE: 21122 | | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): ------- | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk | | | 16b. KIND OF BUSINESS/INDUSTRY: Balto. Gas & Elect. Co. | |
| 17. FATHER'S NAME (First, Middle, Last): William G. Stevens | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Thelma M. Crispens | |
| 19a. INFORMANT'S NAME (Type/Print): William Stevens | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 118 Cloverhill Rd. Pasadena, Md. 21122 | | | |
| 20a. METHDD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____ | | | 20b. PLACE OF DISPOSITION (Neme of cemetary, crematory or other place): Baltimore Cemetery | | 20c. LOCATION — City or Town, State: Balto. City, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Daniel A. Naylor | | | 22. NAME AND ADDRESS OF FACILITY: Pasadena, Md. Rds. McCully Funeral Home, Mt. & Ticlneck | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Septic Shock
DUE TO (OR AS A CONSEQUENCE OF):
b. of Undetermined Sourc.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
(1) Uncontrolled DM (2) HTN
(2) Aspiration

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Sita Yanamadala | | ▶ 4/18/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SITA YANAMADALA, HARBOR HOSP CENTER.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 20 1989 | Julie Davidson-Lindsay |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11385
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| YONDA | STEWART | 4 / 15 / 89 | 2:30 AM |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-78-4641 | 1 ☐ M 2 ☒ F | 24 YRS. | | | 7/11/64 | MD |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Key Medical Center | Baltimore | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | | BALTIMORE | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 5200 EASTERN AVENUE | 21224 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | UNEMPLOYED | NA |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| JACKSON M. STEWART | GOLETTE BRYANT |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| INEZ WOODSON | 820 N. KENWOOD AVENUE BALTO., MD 21205 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | KING MEMORIAL PARK | RANDALLSTOWN, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ William C. March | WM. C. MARCH F/H 1101 E. NORTH AVENUE |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Aspiration pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral palsy

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin M.D. | OCME | ▶ 4-15-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Julia C. Goodin, M.D. 111 Penn St., Balto., MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 18 1989 | Julia Tordson Rodas |

OHMH-18 Rev 1/89

89 11386

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Matthew Dean Streeter
2. DATE OF DEATH: MONTH 4 DAY 13 YEAR 89
3. TIME OF DEATH: 11:00 P. M
4. SOCIAL SECURITY NUMBER: 219-80-6514
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 23 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7 21 1965
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 4905 Grindon Avenue
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: ---------

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore City
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4905 Grindon Avenue
10f. ZIP CODE: 21214
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver
16b. KIND OF BUSINESS/INDUSTRY: Water Well Company
17. FATHER'S NAME (First, Middle, Last): Wayne LaVern Streeter
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Frances Gilbert
19a. INFORMANT'S NAME (Type/Print): Mrs. Mary Frances Streeter
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4905 Grindon Ave. Baltimore, MD 21214
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Carroll Cremation Service
20c. LOCATION — City or Town, State: Hampstead, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stephen M. Jenkins
22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Home 8728 Liberty Road Randallstown, MD 21133

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. PNEUMONIA | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. AQUIRED IMMUNODEFFICIENCY SYNDROME | 3 YEARS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
MALNUTRITION
DEHYDRATION
DIARRHOEA

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient (ONLY NAV) 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Nzeera A Virani MO.
29c. LICENSE NUMBER: D73750.
29d. DATE SIGNED (Month, Day, Year): ▶ 4/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NZEERA A. VIRANI JOHNS HOPKINS HOSPITAL
31. DATE FILED (Month, Day, Year): APR 20 1989
32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11387 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Hattie Mae Sturdivant
Sturdivant, Hattie

**2. DATE OF DEATH** Month: 4 Day: 6 Year: 89

**3. TIME OF DEATH**: 5 20 A M

**4. SOCIAL SECURITY NUMBER**: 213263829

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 75 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 11-9-13

**8. BIRTHPLACE** (State or Foreign Country): MD

**9a. FACILITY NAME** (If not institution, give street and number): University Hospital

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore

**9c. COUNTY OF DEATH**: Balto

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD

**10b. COUNTY**: Baltimore

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 833 W. Pratt St.

**10f. ZIP CODE**: 21201

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**
1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☐ NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: B

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): unemployed

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): Jimme N. McRae

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Nannie McRae

**19a. INFORMANT'S NAME** (Type/Print): Walter Sturdivant

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1000 Wicklow Rd. Baltimore, Md. 21229

**20a. METHOD OF DISPOSITION**
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 8 ☐ Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Cedar Hill Cem.

**20c. LOCATION — City or Town, State**: Brooklyn, Md.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Cecil A Estep

**22. NAME AND ADDRESS OF FACILITY**: Estep Brothers Funeral Home P.A.
1300 Eutaw Place

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiac arrhythmia | hours |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | cardiogenic shock | 48 hrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | myocardial infarction | 48 hrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**
renal failure
anemia

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**
1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide 8 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: A Travaline MD

**29c. LICENSE NUMBER**:

**29d. DATE SIGNED** (Month, Day, Year): 4/6/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print)
John Travaline, MD medical resident

**31. DATE FILED** (Month, Day, Year): APR 20 1989

**32. REGISTRAR'S SIGNATURE**: Julia Henderson-Randall

OHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11388

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Page 1, 2, 3 should be detached for use as the burial-transit permit.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial, cremation, or removal. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEOENT'S NAME (First, Middle, Last): ABAYA Sunness | | 2. DATE OF OEATH (Month, Day, Year): APR. 18, 1989 | 3. TIME OF OEATH: 10:52 AM M |
| 4. SOCIAL SECURITY NUMBER: NONE | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS: 1 / MIN. | 7. DATE OF BIRTH (Month, Day, Year): APR. 18, 1989 — 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF OEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 6512 GLENWICK CT. | 10f. ZIP CODE: 21209 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. OECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 — College (1-4 or 5+): | 16a. OECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NONE | 16b. KIND OF BUSINESS/INDUSTRY: NONE | |
| 17. FATHER'S NAME (First, Middle, Last): FRED SUNNESS | 18. MOTHER'S NAME (First, Middle, Maiden Surname): JANET STOLTZ | | |
| 19a. INFORMANT'S NAME (Type/Print): DR. FRED SUNNESS | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6512 GLENWICK CT. BALTO., MD 21209 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SHOMREI MISHMERES SCHARES HAPLATA | 20c. LOCATION — City or Town, State: ROSEDALE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Sydney L Stillman | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIO-RESPIRATORY ARREST | 1 HR |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ANENCEPHALY — DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. — DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 4/18/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Cecil W. Gaby MD SINAI HOSPITAL | | |
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11389
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): ALEXANDER JOHN SZCZYPINSKI (STOPINSKI)

**2. DATE OF DEATH** MONTH: 4 DAY: 12 YEAR: 89

**3. TIME OF DEATH**: 1130p M

**4. SOCIAL SECURITY NUMBER**: 216-09-2133

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 78 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): August 6, 1910

**8. BIRTHPLACE** (State or Foreign Country): Maryland

**9a. FACILITY NAME** (If not institution, give street and number): Union Memorial Hospital / Union Memorial Hospital

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore City / Baltimore City

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 [X] YES 2 [ ] NO

**10e. STREET AND NUMBER**: 2511 Moore Ave.

**10f. ZIP CODE**: 21234

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Ass't Manager

**16b. KIND OF BUSINESS/INDUSTRY**: A.D.T.

**17. FATHER'S NAME** (First, Middle, Last): Francis Szczypinski

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Mary Not Known

**19a. INFORMANT'S NAME** (Type/Print): Mrs. Camille S. Easley

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3022 Kentucky Ave. Baltimore, Md. 21213

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Moreland Mem. Park 4/15/89

**20c. LOCATION — City or Town, State**: Baltimore, Maryland

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Paul L. Hartsock, Jr. ▶ Paul L. Hartsock, Jr.

**22. NAME AND ADDRESS OF FACILITY**: Baltimore, Maryland 21214 — Leonard J. Ruck, Inc. 5305 Harford Rd.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | pneumonia and ~~other~~ recent MI | 1 day |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF): | probable underlying myelodysplasia | months |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**: sideroblastic anemia.

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [X] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [X] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [X] NO

**26. PLACE OF DEATH** (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year):

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**:

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify):

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Gene Ilm

**29c. LICENSE NUMBER**:

**29d. DATE SIGNED** (Month, Day, Year) ▶ 4/12/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Gene Ilm MD Union Memorial Hospital Balto MD 21218

**31. DATE FILED** (Month, Day, Year): APR 20 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

OHMH-16 Rev 1/89

5

89 11390

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

BALTIMORE, MARYLAND 21203-3146 — DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles Robert Schwarzkopf — CHARLES SCHWARZKOPF
2. DATE OF DEATH — MONTH: 4 DAY: 22 YEAR: 89
3. TIME OF DEATH: 8:40 A M
4. SOCIAL SECURITY NUMBER: 217-07-4666
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 03 16 17
8. BIRTHPLACE (State or Foreign Country): Md.

9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATN: City

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: ----------
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? [X] 1 YES 2 [ ] NO
10e. STREET AND NUMBER: 6420 Hartwait Street
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: W.W. 2
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Reweigh Clerk
16b. KIND OF BUSINESS/INDUSTRY: Esskay Meat Co.

17. FATHER'S NAME (First, Middle, Last): John Schwarzkopf
16. MOTHER'S NAME (First, Middle, Maiden Surname): Rose

19a. INFORMANT'S NAME (Type/Print): Margaret Schwarzkopf
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6420 Hartwait Street Balto., Md. 21224

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify) ____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Saint Stanislaus Cemetery
20c. LOCATION — City or Town, State: Balto. City, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles G. Zeiler
22. NAME AND ADDRESS OF FACILITY: Charles S. Zeiler & Son Inc. 6224 Eastern Ave.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIO PULM FAILURE

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 8 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: PA MD — Swalden MD
29c. LICENSE NUMBER: D27759
29d. DATE SIGNED (Month, Day, Year): ▶ 4 22 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LEFF FOR MED CTR.

31. DATE FILED (Month, Day, Year)
32. REGISTRAR'S SIGNATURE

DNMN-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11391
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Ione Florence Smith

**2. DATE OF DEATH** (Month, Day, Year): April 21, 1989 — APR 21 1989

**3. TIME OF DEATH**: 1:05 ~~AM~~ PM

**4. SOCIAL SECURITY NUMBER**: 212-10-0589

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (in yrs. last birthday): 88 YRS. — IF UNDER 1 YEAR: MONTHS xxxx DAYS x — IF UNDER 24 HRS.: HOURS MIN.

**7. DATE OF BIRTH** (Month, Day, Year): Nov 1, 1905

**8. BIRTHPLACE** (State or Foreign Country): Graceham, MD

**9a. FACILITY NAME** (If not institution, give street and number): 4300 N. Charles St., Apt 10H

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore, MD 21218

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 4300 N. Charles St, Apt 10H

**10f. ZIP CODE**: 21218

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: n/a

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: white

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): homemaker

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): Otho Alexander

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Belva Shipley

**19a. INFORMANT'S NAME** (Type/Print): Mrs. Zilla Johnson

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 112 E. Northern Parkway 21212

**20a. METHOD OF DISPOSITION**: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Security Process Svc.

**20c. LOCATION — City or Town, State**: Balto. Co., MD

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Dean R. Charlton

**22. NAME AND ADDRESS OF FACILITY**: Charlton Funeral Home, 2007 Eastern Avenue, Balto. 21231

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinomatosis, abdomen. — 18 mo.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Carcinoid, bowel — 18 mo.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**: A.C.V.D. - old partial left hemiplegia; Ca. of Kidney

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year):

**28b. TIME OF INJURY**: — M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**:

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify):

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Norman R. Freeman Jr. M.D.

**29c. LICENSE NUMBER**: D02001

**29d. DATE SIGNED** (Month, Day, Year): ▶ Apr. 21, 1989

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): NORMAN R. FREEMAN JR; 4300 N. CHARLES ST - Apt 11G; Baltimore, Md.

**31. DATE FILED** (Month, Day, Year): APR 26 1989

**32. REGISTRAR'S SIGNATURE**: Julia Dendor-Kendall

DHMH-16 Rev 1/89

89 11331

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11392
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): VERNON A. STEPNEY | | | | 2. DATE OF DEATH (Month, Day, Year): 4 14 89 | 3. TIME OF DEATH: 11:10 PM |
| 4. SOCIAL SECURITY NUMBER: 218-82-1259 | 5. SEX: 1 M 2 F | 6. AGE (In yrs. last birthday): 22 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 6-1-66 | 8. BIRTHPLACE (State or Foreign Country): MD |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): street-2200 blk. Brookfield Ave. | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| 10e. STREET AND NUMBER: 824 W. NORTH AVENUE APT. C | | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED | 16b. KIND OF BUSINESS/INDUSTRY: NA | |
| 17. FATHER'S NAME (First, Middle, Last): VERNON STEPNEY | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): SALLY BARBER | |
| 19a. INFORMANT'S NAME (Type/Print): SALLY EDDY | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 824 WEST NORTH AVENUE/BALTIMORE, MD. 21217 | |
| 20a. METHOD OF DISPOSITION: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Zion Cemetery | 20c. LOCATION — City or Town, State: Lansdowne, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vanessa Davis | | 22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple gunshot wounds

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA; OTHER: 4 Nursing Home 5 Residence 5 Other (Specify): Scene |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 5 Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 4-14-89 | 28b. TIME OF INJURY: 11:05P M | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW INJURY OCCURED: Subject shot |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): street | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 2200 blk. Brookfield Ave. Balto. City, MD |

29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-15-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn St., Balto., MD 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 18 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-15 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 ... hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director ... detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11393
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CALVIN PHILLIP SMITH | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 21 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 212-03-3909 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): DECEMBER 13, 1919 | 8. BIRTHPLACE (State or Foreign Country): BALTO. MD. |
| 9a. FACILITY NAME (If not institution, give street and number): FRANCIS SCOTT KEY MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD. | | 9c. COUNTY OF DEATH: BALTO. CITY |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTO. | 10c. CITY, TOWN OR LOCATION: BALTIMORE, MD. | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7511 BERKSHIRE ROAD | | 10f. ZIP CODE: 21224 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: X | | 14. RACE — American Indian, Black, White, etc. Specify: white |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PLUMBER | 16b. KIND OF BUSINESS/INDUSTRY: PLUMBING | | |
| 17. FATHER'S NAME (First, Middle, Last): FREDERICK A. SMITH | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MAMIE SANFT | | |
| 19a. INFORMANT'S NAME (Type/Print): MARY B. SMITH | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7511 BERKSHIRE ROAD BALTO. MD. 21224 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery | 20c. LOCATION — City or Town, State: BALTIMORE, MD. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John J Dippel Jr | 22. NAME AND ADDRESS OF FACILITY: DIPPEL FUNERAL HOME 7110 BELAIR ROAD BALTO. MD. 21206 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio-Pulmonary Collapse | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Cardiac Arrythmia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Hypertensive Cardio-Vascular Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ ND

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Larry G. Tilley MD

29c. LICENSE NUMBER: D 11054

29d. DATE SIGNED (Month, Day, Year): APRIL 24, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Larry G. Tilley 1012 OLD NORTH POINT RD, BALTIMORE, MD.

31. DATE FILED (Month, Day, Year): APR 24 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11394
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Stanley E. Suski | 2. DATE OF DEATH (Month, Day, Year): 4-13-89 | 3. TIME OF DEATH: 3:35PM M | |
| 4. SOCIAL SECURITY NUMBER: 212-03-8959 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Sept. 19, 1919 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 3432 6th Street | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: Baltimore City | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore City | 10c. CITY, TOWN OR LOCATION: Brooklyn | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3432 6th Street | 10f. ZIP CODE: 21225 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW 2 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electronics Technician | 16b. KIND OF BUSINESS/INDUSTRY: Westinghouse | |
| 17. FATHER'S NAME (First, Middle, Last): Andrew T. Suski | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Victoria Zyonous | | |
| 19a. INFORMANT'S NAME (Type/Print): Genevieve M. Hutt | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7984 West Riverside Rd., Pasadena, MD 21122 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Rosary Cemetery | 20c. LOCATION — City or Town, State: Baltimore City, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Kirkley Funeral Home 421 Crain Hwy. S.E., Glen Burnie, MD 21061 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Hypertensive arteriosclerotic cardiovascular disease and
DUE TO (OR AS A CONSEQUENCE OF): XXXXXXXXXXXXXXXX Diabetes

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO INSPECTION | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-14-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin,M.D. | 111 Penn Street,baltimore,MD 21201 | VC |
| 31. DATE FILED (Month, Day, Year): APR 18 1989 | 32. REGISTRAR'S SIGNATURE: [signature] | |

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-11395

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DOROTHY ODESSA SIMMONS | | | | 2. DATE OF DEATH: MONTH April DAY 16 YEAR 1989 | 3. TIME OF DEATH: 12:15 PM |
| 4. SOCIAL SECURITY NUMBER: 218-28-6572 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 74 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1/12/1915 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): UNIVERSITY HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: --- | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: Forest Hill | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 2837 Grier Nursery Road | | 10f. ZIP CODE: 21050 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Home |
| 17. FATHER'S NAME (First, Middle, Last): Tony Grafton | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Esther Ward | |
| 19a. INFORMANT'S NAME (Type/Print): Jean L. Whitsell | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 372 Principio Road Port Deposit, Md. 21904 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Nazarene Cemetery | 20c. LOCATION — City or Town, State: Hickory, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ M. Gladden Kurtz | | 22. NAME AND ADDRESS OF FACILITY: Kurtz Funeral Home Jarrettsville, Maryland 21084 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. PROBABLE SEPSIS | one week |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. VENTRICULAR ARRYTHMIAS | 2 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CONGESTIVE HEART FAILURE

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one):
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M.D. RESIDENT | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ April 16 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN GARY EVANS / University Hospital 22 S. Greene St 21201 | | |
| 31. DATE FILED (Month, Day, Year): APR 19 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 11396

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal from State.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LILY BELL SHOEMAKER | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 29, 1989 | 3. TIME OF DEATH: 4:28A M |
| 4. SOCIAL SECURITY NUMBER: 266 26 7617 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Aug 11 1911 | 8. BIRTHPLACE (State or Foreign Country): Florida |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Dundalk | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 101 Center Place | | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Beautican | 16b. KIND OF BUSINESS/INDUSTRY: Beauty Shop | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Poole | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lilla Rae Tillman | |
| 19a. INFORMANT'S NAME (Type/Print): Mra Joeann Westbrook | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6501 Corkley Rd Baltimore, Maryland 21237 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garden Of Faith | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: WALTER BROOKS BRADLEY, INC. 2134 PILLOW SPRING ROAD, BALTIMORE, MARYLAND 21222 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. AORTIC OCCLUSION | ~30 hours |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. S/P TRANSHIATAL ESOPHAGECTOMY | ~36 hours |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. ESOPHAGEAL CARCINOMA | > 4 MONTHS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

① S/P VISCERAL REVASCULARIZATION; CELIAC, SMA AND RENAL ENDARTECTOMIES WITH AORTOBIFEMURAL BYPASS
② HYPERTENSION

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Kenneth Anderson (House Staff) | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 04/29/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): KENNETH A. ANDERSON JOHNS HOPKINS HOSP., BALTO., MD. | | |
| 31. DATE FILED (Month, Day, Year): MAY 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 1396

89 11397

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
| MICHAEL (Mike) NATHANIEL (SAULSBURY) Salsbury | | | | 4-30-89 | 10:50PM M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
| 214-80-5791 | 1 XX M 2 ☐ F | 27 YRS. | | 1-3-62 | MD |
| 9a. FACILITY NAME (If not institution, give street and number) | | 9b. CITY, TOWN OR LOCATION OF DEATH | | 9c. COUNTY OF DEATH | |
| Johns Hopkins Hospital | | Baltimore City | | | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | | BALTIMORE CITY | 1 XX YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 2115 BELAIR ROAD | 21213 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES XX NO IF YES, GIVE WAR OR DATES | 1 ☐ YES XX NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| HIGH SCHOOL | | RESTURANT | NA |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| PAUL SAULSBURY | ANN MARIE HOPE |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| PAUL SAYLSBURY | 2115 BELAIR ROAD/BALTIMORE, MD 21213 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | EASTVIEW MEMORIAL PK. CEMETERY | DUNDALK, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ [signature] | WILLIAM C, MARCH F.H. 1101 E. NORTH AVENUE |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Gunshot wound to chest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XX YES 2 ☐ NO | XX YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| XX YES 2 ☐ NO | HOSPITAL: XX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide XX 4 Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 4-30-89 | 10:17 M | 1 ☐ YES XX NO | subject shot |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| | (in front) dwelling | | | 507 N. Collington Avenue |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | OCME | ▶ 5-1-89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | |
|---|---|
| James Kaplan,M.D. | 111 Penn Street,Baltimore,MD 21201 VC |

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 4 _ 1989 | Julia Davidson-Randolph |

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11398
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE STEVENS
2. DATE OF DEATH: MONTH 4 DAY 25 YEAR 89
3. TIME OF DEATH: 906 A M
4. SOCIAL SECURITY NUMBER: —
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 1 MONTH YRS. IF UNDER 1 YEAR: MONTHS 1 DAYS 2 IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-23-89
8. BIRTHPLACE (State or Foreign Country): BALTO. Md.
9a. FACILITY NAME (If not institution, give street and number): MT. WASHINGTON PED. HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 827 LINDEN AVENUE
10f. ZIP CODE: 21201
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NONE
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): GEORGE STEVENS
18. MOTHER'S NAME (First, Middle, Maiden Surname): ALISA BLUE
19a. INFORMANT'S NAME (Type/Print)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): King Mem Park
20c. LOCATION — City or Town, State: Randallstown, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dale March
22. NAME AND ADDRESS OF FACILITY: March F.H. West 2300 Wabash Ave

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac and Respiratory arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Holoprosencephaly, Cleft Lip, Cleft palate

DUE TO (OR AS A CONSEQUENCE OF):

c. Enucleated eye, Anomalies Head & Feet,

DUE TO (OR AS A CONSEQUENCE OF):

d. Fused Digit, Amniotic Band and Amputation of Extremities

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Holoprosencephaly

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Martha T Greene
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): 4/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Maryland General Hospital
31. DATE FILED (Month, Day, Year): MAY 4 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11399
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Albina Sargent
2. DATE OF DEATH (Month, Day, Year): 4 20 89
3. TIME OF DEATH: 405 P M
4. SOCIAL SECURITY NUMBER: 031-20-7013
6. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 62 YRS. (If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.)
7. DATE OF BIRTH (Month, Day, Year): Oct. 3, 1926
8. BIRTHPLACE (State or Foreign Country): Massachusetts
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4507 Clareway
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☒ YES 2 ☐ NO Specify: Spanish
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary
16b. KIND OF BUSINESS/INDUSTRY: Church
17. FATHER'S NAME (First, Middle, Last): Robert Pitt
18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Morris
19a. INFORMANT'S NAME (Type/Print): Mark Sargent
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 518 Old Home Rd., Baltimore, MD 21206
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery
20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: R. George Altenburg
22. NAME AND ADDRESS OF FACILITY: ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. hypoxia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. pulmonary embolus | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. deep venous thrombosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: glioblastoma multiforme

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Marc R. Blackman MD.
29c. LICENSE NUMBER: D18146
29d. DATE SIGNED (Month, Day, Year): April 20, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M. CHISOLM
31. DATE FILED (Month, Day, Year): APR 25 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11400
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROBERT M. SCURTO | | | 2. DATE OF DEATH (Month, Day, Year): 04 17 1989 | 3. TIME OF DEATH: 705 PM |
| 4. SOCIAL SECURITY NUMBER: 216-12-0174 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 65 YRS. (If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.) | 7. DATE OF BIRTH (Month, Day, Year): 10/28/23 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: ---------- |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore County | 10c. CITY, TOWN OR LOCATION: Towson | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 8201-F Loch Raven Blvd. | | 10f. ZIP CODE: 21204 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. OECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 Years; College (1-4 or 5+): ---------- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Assembly | 16b. KIND OF BUSINESS/INDUSTRY: Auto | |
| 17. FATHER'S NAME (First, Middle, Last): Angelo Scurto | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Myrtle Peterson | |
| 19a. INFORMANT'S NAME (Type/Print): Fannie R. Scurto | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8201-F Loch Raven Blvd.Towson, MD 21204 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith | 20c. LOCATION — City or Town, State: Balto.Co.,Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William E. Johnson | 22. NAME AND ADDRESS OF FACILITY: William E. Johnson Funeral Home 8521 Loch Raven Blvd.Towson,MD21204 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Transitional Cell Ca | |
| DUE TO (OR AS A CONSEQUENCE OF): | b. Thrombocytopenia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): | c. Neutropenia | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Intern attde Osh. | | ▶ 4/17/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): XENOPOULOS NICHOLAOS.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| 4/APR 89 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 11401

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Last: Smith, First: Albirtha.

2. DATE OF DEATH: Month 4, Day 26, Year 89

3. TIME OF DEATH: 325 PM

4. SOCIAL SECURITY NUMBER: 219-38-6834

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 66 YRS. — IF UNDER 1 YEAR: MONTHS ✓ DAYS — IF UNDER 24 HRS.: HOURS MIN.

7. DATE OF BIRTH (Month, Day, Year): 12 5 22

8. BIRTHPLACE (State or Foreign Country): Baltimore, MD

9a. FACILITY NAME (If not institution, give street and number): Liberty Med. Center

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 912 N. Arlington Ave

10f. ZIP CODE: 21217

10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic

16b. KIND OF BUSINESS/INDUSTRY: Pvt Family

17. FATHER'S NAME (First, Middle, Last): Emmanuel Johnson

18. MOTHER'S NAME (First, Middle, Maiden Surname): Doa

19a. INFORMANT'S NAME (Type/Print): Berry Johnson

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5215 Floodcrest Rd Baltimore, MD 21229

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Western Star

20c. LOCATION — City or Town, State: Baltimore, MD 21228

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Marshall P. Hayes

22. NAME AND ADDRESS OF FACILITY: Marshall P. Hayes F.H. 438 W. Gilmor Street

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Pos Pulmonary Embolism.
DUE TO (OR AS A CONSEQUENCE OF):
c. Arteriosclerotic heart dis., COPD
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Adenocarcinoma of Colon with lower G.I. bleeding.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) —

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED —

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) —

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: D25722[illegible]8

29d. DATE SIGNED (Month, Day, Year): ▶ 4/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ashok Agrawal

31. DATE FILED (Month, Day, Year): APR 28 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Rohde

OHMH-16 Rev 1/89

89 11F01

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11402
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Evelyn F. Showalter | | | 2. DATE OF DEATH (Month, Day, Year): 4-25-89 | 3. TIME OF DEATH: 2:25PM M |
| 4. SOCIAL SECURITY NUMBER: 214-20-3448 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11/23/00 | 8. BIRTHPLACE (State or Foreign Country): Baltimore |
| 9a. FACILITY NAME (If not institution, give street and number): 3900 N. Charles Street | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3900 N. Charles St. | | 10f. ZIP CODE: 21012 | 10g. CITIZEN OF WHAT COUNTRY? |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Ret. Nurse | 16b. KIND OF BUSINESS/INDUSTRY: Hopkins Hospital | |
| 17. FATHER'S NAME (First, Middle, Last): Henry C. Faupel | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara M. Hubert | |
| 19a. INFORMANT'S NAME (Type/Print): Herold R. Bohlman | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1224 Old County Rd. Arnold, Md. 21012 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Entombment | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge | 20c. LOCATION — City or Town, State: Pikesville | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John A Hicks | 22. NAME AND ADDRESS OF FACILITY: Henry W. Jenkins & Sons 4905 York Rd. Balto. Md. 21212 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hypertensive arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |
| INSPECTION | |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Charles P. Kokes MD | OCME | ▶ 4-25-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. KOkes, M.D. 111 Penn Street, Baltimore, MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 2 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11403
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): James Stevenson | | 2. DATE OF DEATH (Month, Day, Year): April 27, 1989 | 3. TIME OF DEATH: 7:19A M |
| 4. SOCIAL SECURITY NUMBER: 216-09-0621 | 5. SEX: 1 [#] M 2 [ ] F | 6. AGE (In yrs. last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 6/28/18 — 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [#] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2617 Edmondson Ave. | | 10f. ZIP CODE: 21223 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [#] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [#] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: W.W. 2 | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Edward Stevenson | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosie Hill |
| 19a. INFORMANT'S NAME (Type/Print): Stephanie Stevenson | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2617 Edmondson Ave. Baltimore, Md. 21223 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [#] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veterans | 20c. LOCATION — City or Town, State: Owings Mills, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Estep | 22. NAME AND ADDRESS OF FACILITY: Estep Brothers Funeral Home P.A. 1300 Eutaw Place | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceuaed the death. Do not anter the mode of dying, auch aa cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Disseminated prostatic carcinoma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Neutropenia

Possible Sepsis

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: James J. Cole, MD | 29c. LICENSE NUMBER: n/a | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/27/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James J. Cole, M.D. | c/o Maryland General Hospital | |
| 31. DATE FILED (Month, Day, Year): MAY 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 11404

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Louis ALFRED Steinwedel | | | | 2. DATE OF DEATH (Month, Day, Year): April 26, 1989 | 3. TIME OF DEATH: 10:50A M |
| 4. SOCIAL SECURITY NUMBER: 215-24-7359 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 78 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10-25-10 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: N/A |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: N/A | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2906 Manhattan Ave. | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bookbinder | 16b. KIND OF BUSINESS/INDUSTRY: Bank Stationary | |
| 17. FATHER'S NAME (First, Middle, Last): William Frederick Steinwedel | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lottie Virginia Zink | |
| 19a. INFORMANT'S NAME (Type/Print): Louis Wm. Steinwedel | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2906 Manhattan Ave. Balto. Md. 21215 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge | 20c. LOCATION — City or Town, State: Pikesville Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis Stephen Kenakt | | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld 6500 York Rd 21212 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Clostridium difficile colitis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Possible pneumonia

Hypertension

Possible ischemic bowel

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: IAN TANG MD | 29c. LICENSE NUMBER: n/a | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/26/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ian Tang, M.D. | | c/o Maryland General Hospital |
| 31. DATE FILED (Month, Day, Year): APR 28 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Kinsale | |

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11405
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BURNELL STOKES | | | | 2. DATE OF DEATH (Month, Day, Year): 4 27 89 | 3. TIME OF DEATH: 1:00 A M |
| 4. SOCIAL SECURITY NUMBER: 213-12-1427 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 70 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8-25-18 | 8. BIRTHPLACE (State or Foreign Country): WEST VA. |
| 9a. FACILITY NAME (If not institution, give street and number): 2638 KIRK AVE | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTO CITY | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: MD | 10b. COUNTY: — | 10c. CITY, TOWN OR LOCATION: BALTO | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2638 KIRK AVE | | 10f. ZIP CODE: 21218 | | 10g. CITIZEN OF WHAT COUNTRY? USA. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BRICK LAYER | | 16b. KIND OF BUSINESS/INDUSTRY: CONSTRUCTION | |
| 17. FATHER'S NAME (First, Middle, Last): JAMES STOKES | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LILLIE HURT | | |
| 19a. INFORMANT'S NAME (Type/Print): FLORENCE STOKES | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2638 KIRK AVE BALTO MD 21213 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE CEMETERY | | 20c. LOCATION — City or Town, State: BALTO, | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bette Funeral Home | | 22. NAME AND ADDRESS OF FACILITY: 1129 N. CAROLINE St BALTO MD 21213 | | | |

## TO BE COMPLETED BY PHYSICIAN; MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma of lung with DUE TO (OR AS A CONSEQUENCE OF): | 6 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ~~DUE TO (OR AS A CONSEQUENCE OF):~~ | |
| | c. metastases to neck and pharynx DUE TO (OR AS A CONSEQUENCE OF): | 6 months |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| W.B. Daniels, Jr. MD | D-02225 | ▶ 5/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): W.B. Daniels, Jr. MD Union Memorial Hospice, Balto 21218

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 2 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 11405

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11406
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) SMITH John R. Robert Smith JOHN Sr. | | | 2. DATE OF DEATH Month 4 Day 27 Year 89 | 3. TIME OF DEATH 8:15 A M |
| 4. SOCIAL SECURITY NUMBER 216-18-7407 | 5. SEX 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday) 65 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) 4/25/1924 | 8. BIRTHPLACE (State or Foreign Country) Maryland |
| 9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH ---- |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE Maryland | 10b. COUNTY --- | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER 1620 Plum Street | | 10f. ZIP CODE 21226 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 10 / College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painting | | 16b. KIND OF BUSINESS/INDUSTRY Self-employed |
| 17. FATHER'S NAME (First, Middle, Last) William Otis Smith | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes May Eckert Smith | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Roland A. Smith, Sr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Will-O-Brook Dr., Pasadena, Md. 21122 | | |
| 20a. METHOD OF DISPOSITION 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ X E E Kevin E. Ecker | | 22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC SQUAMOUS CELL CARCINOMA OF LUNG

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Marian Jones Benner Hosp Pathologist | D37693 | ▶ 4/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARIAN BENNER 3171 S. HANOVER ST BALTO. MD 21230

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 2 1989 | |

DNMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11407
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elizabeth Roselie Shemenski
2. DATE OF DEATH (Month, Day, Year): 4 27 89
3. TIME OF DEATH: 1210 PM
4. SOCIAL SECURITY NUMBER: 215-01-8319
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-29-12
8. BIRTHPLACE (State or Foreign Country): Ohio
9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: ----
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1517 Locust Street,
10f. ZIP CODE: 21226
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired Seamstrees
16b. KIND OF BUSINESS/INDUSTRY: Stetson Dee Clothes
17. FATHER'S NAME (First, Middle, Last): Andrew Peterson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Magdalena Kwizikiewicz Peterson
19a. INFORMANT'S NAME (Type/Print): Mr. Walter A. Shemenski
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1517 Locust St., Baltimore, Maryland 21226
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Cross Cemetery
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kevin E. Ecker — ▶ K E Ecker
22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Brooklyn, 237 E. Patapsco Ave., Balto., Md. 21225

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Acute Respiratory Failure | minutes |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Aspiration | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Seizure | |
| d. | possible mI (acute) | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: previous MI

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature], MD House Physician
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 04-27-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James V. TREMAGLI, M.D. Harbor Hosp Ctr Baltimore, Md
31. DATE FILED (Month, Day, Year): 04-27-1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11408
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DANNY Stephen SCOTT | | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 28, 1989 | 3. TIME OF DEATH: 8:13A M |
| 4. SOCIAL SECURITY NUMBER: 259-35-9734 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 22 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Feb. 6, 1967 | 8. BIRTHPLACE (State or Foreign Country): Georgia |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Georgia | 10b. COUNTY: Stephens | 10c. CITY, TOWN OR LOCATION: Toccoa | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: RT.3 Black Mountain Road | | 10f. ZIP CODE: 30577 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Press Operator | 16b. KIND OF BUSINESS/INDUSTRY: Auto Parts Manufacturer | |
| 17. FATHER'S NAME (First, Middle, Last): Hoyt Scott | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Jewel Weaver | |
| 19a. INFORMANT'S NAME (Type/Print): Hoyt Scott | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RT. 3 Black Mountain Road Toccoa, Georgia 30577 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Old Toccoa Baptist Church Cemetery | 20c. LOCATION — City or Town, State: Toccoa, Georgia |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael P. Marzullo | | 22. NAME AND ADDRESS OF FACILITY: Marzullo Funeral Service 3981 Carrollton Road Upperco, MD. 21155 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be detached by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, [illegible] be signed for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified before disposition.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Gastric bleeding | 24 hours |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Gastric varices | 1 year |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | hepatocellular carcinoma | 3 years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | Hepatitis B | >10 years |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Earl Hope MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/28/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Earl Hope MD Johns Hopkins Hospital Balto MD 21205

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

4

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 11409
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. [illegible] as the burial-transit permit. Pages 1, 2, 3 should
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARY SHARON | | | | 2. DATE OF DEATH (Month, Day, Year): 4 21 89 | 3. TIME OF DEATH: 10 A M |
| 4. SOCIAL SECURITY NUMBER: 220 24 0250 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 60 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 4/18/1929 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): LEVINDALE | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTO | | 9c. COUNTY OF DEATH: Baltimore City |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | CECIL | Perryville | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 345 Broad Street | 21903 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12): 8th | College (1-4 or 5+): | HOmemaker | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Frank E. Jackson, Sr. | Blanch O. Devonshire |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Blanch O. Caldwell | 251 Wilson St., Havre de Grace, MD 21078 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Union Cemetery | Cecil Co., MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ William S. Smith II | Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CEREBROVASCULAR ACCIDENT | 2 1/2 MONTHS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CANCER OF ESOPHAGUS

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Hinesman M.D. | D 23500 | ▶ 4-21-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 24 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 11403

89 11410

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): LAURA SMITH (LAURA M. SMITH)
2. DATE OF DEATH: MONTH 4 DAY 2 YEAR 89
3. TIME OF DEATH: 8:00pm M
4. SOCIAL SECURITY NUMBER: 244-74-7101
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 84 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8/12/04
8. BIRTHPLACE (State or Foreign Country): N.C.
9a. FACILITY NAME (If not institution, give street and number): ST. AGNAS HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4633 MARBLE HALL ROAD
10f. ZIP CODE: 21239
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNKNOWN
16b. KIND OF BUSINESS/INDUSTRY: RETIRED
17. FATHER'S NAME (First, Middle, Last): DAVID WATSON
18. MOTHER'S NAME (First, Middle, Maiden Surname): MITTIE CAMPBELL
19a. INFORMANT'S NAME (Type/Print): KATIE ALSTON
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4633 MARBLE HALL ROAD/BALTIMORE, MD. 21239
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WATERING HOLE CEMETERY
20c. LOCATION — City or Town, State: MAXTON, N.C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: 1101 E. NORTH AVENUE 21202 — WILLIAM C. MARCH FUNERAL HOME

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CVA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Know the Cause
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 4/2/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print):
31. DATE FILED (Month, Day, Year): APR 5 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11411
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Donnie JOE Spears | | | 2. DATE OF DEATH (Month, Day, Year): 4-10-89 | 3. TIME OF DEATH: 1:05PM M |
| 4. SOCIAL SECURITY NUMBER: UNKNOWN | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 39 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3-22-50 | 8. BIRTHPLACE (State or Foreign Country): N.C. |
| 9a. FACILITY NAME (If not institution, give street and number): Johns Hopkins Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 319 EAST 20th STREET | | 10f. ZIP CODE: 21218 | | 10g. CITIZEN OF WHAT COUNTRY: USA |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER | | 16b. KIND OF BUSINESS/INDUSTRY: FULLTIME |
| 17. FATHER'S NAME (First, Middle, Last): WALTER M. SPEARS | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): JESSIE L. BENJAMIN | | |
| 19a. INFORMANT'S NAME (Type/Print): MARY ANN SPEARS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 92 COREY AVENUE/CONCORD, N.C. 28025 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): RUTHERFORD CEMETERY | | 20c. LOCATION — City or Town, State: CONCORD, N.C. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald Gaitto | | 22. NAME AND ADDRESS OF FACILITY: WILLIAM C. MARCH F.H. 1101 E. NORTH AVENUE | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Gunshot wound to head
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XX ☒ YES 2 ☐ NO | XXX ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 XX ☒ YES 2 ☐ NO | HOSPITAL: XX ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide XX 4 ☒ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 4-8-89 | 1:38AM | 1 ☐ YES XX ☒ NO | Subject shot |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 319 E. 28th Street |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Charles P. Kokes MD | OCME | ▶ 4-11-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn Street, Baltimore, MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 12 1989 | Julia Madison-Mondell |

DHMH-16 Rev 1/89

89 11411

89 11412

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LOIS M SPENCE | | | 2. DATE OF DEATH (Month, Day, Year): APR 2, 1989 | 3. TIME OF DEATH: 255P M |
| 4. SOCIAL SECURITY NUMBER: 217227142 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 64 63 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 050925 | 8. BIRTHPLACE (State or Foreign Country): S.C. |

| | | | |
|---|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): Homewood Hospital Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: — | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 908 E. 20th St. Balto, Md. 21218 | 10f. ZIP CODE: 21218 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Physical Clerk | 16b. KIND OF BUSINESS/INDUSTRY: State | |
| 17. FATHER'S NAME (First, Middle, Last): Alfred Miller | 16. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN | | |
| 18a. INFORMANT'S NAME (Type/Print): Andrew Miller | 18b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 915 Rutland Ave. Baltimore, Md. 21205 | | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Randolph J. Collick | 22. NAME AND ADDRESS OF FACILITY: 2431 E. Oliver St. Collick Funeral Home Balto, Md. 21213 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ADULT RESPIRATORY DISTRESS SYNDROME | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. PNEUMONIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☑ NO | 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): NA | 28b. TIME OF INJURY: NA M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☑ NO | 28d. DESCRIBE HOW INJURY OCCURED: NA |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): NA | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): NA. | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: G S Walia MD, RESIDENT PHYSICIAN | 29c. LICENSE NUMBER: | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/2/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): G. S. WALIA, MD, HOMEWOOD HOSP. CTR, 2724 CHARLES ST, BALTIMORE, MD 21218

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 5 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11413 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 shall be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DORA R. SPORER
2. DATE OF DEATH (Month, Day, Year): APR 3 1989
3. TIME OF DEATH: 2⁰⁰ P.M.
4. SOCIAL SECURITY NUMBER: 072-07-5734
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): OCT 31 1903
8. BIRTHPLACE (State or Foreign Country): NEW YORK
9a. FACILITY NAME (If not institution, give street and number): 12911 GENT ROAD
9b. CITY, TOWN OR LOCATION OF DEATH: REISTERSTOWN
9c. COUNTY OF DEATH: BALTIMORE

**RESIDENCE OF DECEDENT**

10a. STATE: MD
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: REISTERSTOWN
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 12911 GENT ROAD
10f. ZIP CODE: 21136
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEOENT EVER IN U.S. ARMEO FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): AT HOME
16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): MICHAEL EASTERLY
18. MOTHER'S NAME (First, Middle, Maiden Surname): DORA HART
19a. INFORMANT'S NAME (Type/Print): WILLIAM M. SPORER
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12911 GENT ROAD REISTERSTOWN 21136

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ALL SAINTS CEMETERY
20c. LOCATION — City or Town, State: REISTERSTOWN

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Frances C. Evans
22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF CHIMES 2325 YORK RD, TIMONIUM

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC BREAST CANCER — Approximate Interval Between Onset and Death: YEARS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. _____ DUE TO (OR AS A CONSEQUENCE OF):
c. _____ DUE TO (OR AS A CONSEQUENCE OF):
d. _____

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: John H. Lavin MD
29c. LICENSE NUMBER: D 20795
29d. DATE SIGNED (Month, Day, Year): ▶ 4-4-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print): JOHN G. LAVIN MD ; 7402 YORK RD ; STE 102 TOWSON, MD 21204
31. DATE FILED (Month, Day, Year): APR 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

89 11414

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Data may be obtained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in the registrar's office, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LARRY STANFIELD | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 03, 1989 | 3. TIME OF DEATH: 1:00 P M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 36 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8-22-52 | 8. BIRTHPLACE (State or Foreign Country): MD |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: — | 10c. CITY, TOWN OR LOCATION: BALTO. | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2000 PARK AVE | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: NEGRO |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Delivery Driver | 16b. KIND OF BUSINESS/INDUSTRY: Driver |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): SAM STANFIELD | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ESSIE BLACKWELL |
| 19a. INFORMANT'S NAME (Type/Print): Christine Pullen | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3511 Melody Lane Balto. md |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Mem Pk | 20c. LOCATION — City or Town, State: Arbutus MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Betts Funeral Home | 22. NAME AND ADDRESS OF FACILITY: 1129 N. Caroline St | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. PNEUMOCYSTIS PNEUMONIA | 6 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. AQUIRED IMMUNODEFICIENCY SYND — 2 YRS - ROME | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: THROMBOCYTOPENIA.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☒ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Nzeera A Virani MD | 29c. LICENSE NUMBER: D73750 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NZEERA A. VIRANI MD.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): 4/3 APR 5 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 11415
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2-3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): PASQUALE A. STAVOLA | | | | 2. DATE OF DEATH (Month / Day / Year): 4 / 3 / 89 | 3. TIME OF DEATH: 10.20 AM |
| 4. SOCIAL SECURITY NUMBER: 216 24 22 39 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 59 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 6/11/29 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Med. Cen. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Maryland | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore, Maryland | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6448 O'Donnell Street | | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): barrell-wood joiner | 16b. KIND OF BUSINESS/INDUSTRY: Kimball Tyler | |
| 17. FATHER'S NAME (First, Middle, Last): Gaetano Stavola | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Maria DiBuono | |
| 19a. INFORMANT'S NAME (Type/Print): Dorothy Stavola | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6448 O'Donnell Street, 21224 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Cemetery | 20c. LOCATION — City or Town, State: Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph N. Zannino Jr. | | 22. NAME AND ADDRESS OF FACILITY: Joseph N. Zannino Funeral Home 263 S. Conkling Street, 21224 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SEPSIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. UPPER GI HEMMORHAGE | 10 HOURS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. ACUTE RENAL FAILURE | 6 DAYS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. PSEUDOMONAS / PROTEUS PNEUMONIA | 9 DAYS |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Edward P. Golucke M.D. | 29c. LICENSE NUMBER: D2539 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/3/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
| 31. DATE FILED (Month, Day, Year): APR 5 1989 | 32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall | |

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89 11415